SECTION V.
Special Needs Populations

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Introduction

This section discusses the housing and community development needs of special needs populations in Indiana, pursuant to Sections 91.305 and 91.315 of the State Government Consolidated Plan Regulations.

Due to lower incomes and the need for supportive services, special needs groups are more likely than the general population to encounter difficulties finding and paying for adequate housing and often require enhanced community services. The groups discussed in this section include:

- Youth;
- The elderly;
- Persons experiencing homelessness;
- Persons with developmental disabilities;
- Persons with HIV/AIDS;
- Persons with physical disabilities;
- Persons with mental illnesses and/or substance abuse problems; and
- Migrant agricultural workers.

A list of data sources used in assessing the needs of these populations is provided at the end of this section.

Individuals with extremely low- and very low-incomes are also considered a special needs group by many policymakers and advocates. Because the needs of this group are given attention in other sections of this report, low-income populations are not included here as a specific special needs group.

Summary

- Each year there are approximately 800 youth who are "aging out" of foster care in Indiana. Research reveals that 3 out of 10 of the nation's homeless are former foster children, and homeless parents who have a history of foster care are almost twice as likely to have their own children placed in foster care as homeless people who were never in foster care. The need for safe, affordable housing is a central issue identified by young adults who have aged out of foster care. These young adults need transitional housing with supportive services, rental vouchers with supportive services, and affordable housing.

- There were 757,451elderly persons living in Indiana in 2002. The 2000 Census reports that 35 percent of senior homeowners and 98 percent of senior renters are cost-burdened (paying more than 30 percent of their income to housing). Approximately one-third of seniors age 65 to 74 indicated disability status in the 2000 Census; this statistic rises to over one-half of seniors over age 75. With the total elderly population projected to grow to 760,728 by 2005 and 809,460 by 2010, the likely trend is for the magnitude of these needs to increase.

- The 2000 Census point-in-time count of emergency and transitional shelters identified approximately 2,384 persons experiencing homelessness in shelters throughout the State. The latest data from the Continuum of Care (2003) estimate the Statewide population of persons experiencing homelessness at 15,177. According to Census, an estimated 460,000 households are cost-burdened – i.e., their rent or mortgage payment constitutes more than 30 percent of their monthly income – placing them at risk of homelessness.

- According to a 2000 study conducted by the Association of Rehabilitation Facilities of Indiana, there are approximately 70,000 persons with developmental disabilities in Indiana. The trend in serving these individuals is to move away from institutional care toward small group homes and integrated community settings. Through objectives and goals established as a result of the recent Olmstead initiative, Indiana is making considerable progress toward the full community integration of persons with developmental disabilities.

- The AIDS Housing of Washington completed the *Indiana HIV/AIDS Housing Plan* in February 2003. According to the study, as of June 2002 there were 3,368 people living with AIDS and another 3,668 people living with HIV who have not been diagnosed with AIDS. According to Indiana's Department of Health there were 7,036 people living with HIV in Indiana as of December 2003. Data also indicate that between 2,150 and 3,853 people living with HIV/AIDS in Indiana need housing, but there are currently only 143 dedicated facility-based units (79 of these units are located in the City of Indianapolis) to persons living with HIV/AIDS. An additional 98 persons receive long-term rental assistance and 203 persons receive short-term rental assistance through HOPWA from July 1, 2003 to February 2004. Persons with HIV/AIDS typically face a number of challenges in obtaining housing that meets their needs (e.g., requirements for health services).

- The 2000 Census reported 1,052,757 Hoosiers over the age of five who indicated having some type of disability. Approximately 734,000 of these persons reside in nonentitlement areas. Of all types of disabilities, physical disability is the most prevalent, comprising one-quarter of all types of disabilities. According to a recent research report by the Governor's Council for People with Disabilities, the top three "key issues" for Indiana residents with disabilities include: expanding home and community based services; shortening waiting lists for community based services; and fully utilizing Vocational Rehabilitation Services funds.
- There are approximately 236,000 individuals with mental illnesses in Indiana, 68,000 of whom are low-income and are the target of programs offered by the Division of Mental Health. The Division serves an additional 25,000 people at any one time with substance abuse problems. A 2001 survey by the Indiana National Alliance for the Mentally Ill (NAMI) of Community Mental Health Centers (CHMC) identified over 1,900 beds throughout the State for persons with mental illness. Although the survey found a near even number of units in entitlement and nonentitlement areas, funding of housing programs and other resources for these individuals is weighted toward cities.
- There are no recent studies of the needs of migrant agricultural workers in Indiana. Findings from studies at the national level estimate the number of migrant agricultural workers in the State to be about 8,000. Although housing for these workers is historically provided by the growers, this housing is often overcrowded, with several families residing under one roof. Many of the existing housing units are of substandard quality and are not well maintained. The housing needs of migrant agricultural workers are hard to quantify due to the lack of data at the State level. However, national data indicate that the need for affordable quality housing is great.

Youth

Because of growing concerns Statewide of the needs of youth in transition from out-of-home care, the Consolidated Plan is including this group as a special needs population for the first time in the 2004 Update. This section details the most current research about the needs of this population.

Population. Each year there are between 20,000 and 25,000 youth aged 16 and older that transition from the foster care system to independent living nationwide. Youth in foster care often do not get the help they need with high school completion, employment, accessing health care, continued educational opportunities, housing and transitional living arrangements. Typically, the foster care system expects the youth to live on their own at age 18. Indiana has approximately 800 youth who are released from substitute care each year.

On March 27, 2000, the Census identified approximately 2,384 persons staying in emergency and transitional shelters of this type Statewide. Of these persons, 26 percent were under 18 years of age.

Outstanding need. The Social Science Research Center of Ball State University of Indiana completed a study, *Indiana Independent Living Survey of Foster Youth,* in December 2003 of foster youths. The survey asked 247 youth in foster care (ages 14 to 18 years) from more than 40 of the 92 counties in Indiana information regarding the characteristics, experiences and needs of young people and offered these individuals the opportunity to voice their opinions regarding needs and resources. Approximately 28 percent of the youth lived in rural areas and the remaining in urban areas.

Over half (52.5 percent) of the youth stated that they did not know where they were going to live when emancipated. Additionally, 108 youths (44.3 percent) indicated they were *not* aware of housing options available upon emancipation. The youth who did know of housing options said they were informed mostly by their Division of Family and Children case manager (37.5 percent) or their independent living program staff (25.7 percent).

Almost three-fourths (74 percent of those surveyed) stated that they would stay with their foster parents, if possible, when asked if they would like to stay with their foster parents after emancipation or aging out. On average, the youth wanted to stay 2.06 years.

The study also reports Indiana youths who participated in focus groups in 2002 expressed an interest in better housing options when they left care. They stated they would need furnished housing and possibly roommates to share the bills. A suggestion by the participants included housing similar to the secure housing provided for seniors.

The study also provided recommendations on housing options for youth. These included:

- Given the cost of housing (in 2002, fair market rent for a two bedroom apartment in Indiana was $568 per month, or 68.9 percent of the average monthly income for a worker earning federal minimum wage – CWLA, 2003), it is important that "budgeting" becomes an essential part of independent living programming and services.

- Participate and cooperate fully with the Consolidated Plan Coordinating Committee as they begin research for the FY 2004 update.

- Continue statewide representation at the annual Consolidated Plan meetings.

- Educate local housing authorities and local offices of the Division of Family and Children about foster youths being an eligible recipient of a Family Unification Program (FUP) voucher.

- Encourage those communities that have FUP vouchers to designate a certain number for those young people aging out of foster care.

- Support and encourage state agencies and local housing authorities to apply to HUD for FUP vouchers.

- Encourage service providers to apply for federal funds to operate Transitional Living Programs.

- Increase the number of service providers that provide Chafee room and board services, especially in the rural areas of the state.

- Survey services providers regarding programming obstacles they face when helping a youth transition into housing arrangements.

National studies have shown that most youth transitioning from in-home care to self-sufficiency do not appear to have the needed supports to be self-sufficient. Since 1986, the federal government has provided funding for states to develop independent living programs to prepare foster care youth for adulthood. Independent living services typically offer assistance with money management, health and safety, locating and maintaining housing, food and nutrition, community resources, career planning, and social skills development.

However, national studies of youth who have left foster care show that 12 to 18 months after leaving foster care:

- 40 percent end up homeless
- 50 percent are unemployed
- 37 percent do not have a high school diploma or GED
- 33 percent are on public assistance
- 30 percent have children
- 27 percent of the males and 10 percent of the females have been incarcerated

Research also shows that three out of ten of the nation's homeless are former foster children, and homeless parents who have a history of foster care are almost twice as likely to have their own children placed in foster care as homeless people who were never in foster care. Several studies document that anywhere from 10 to 25 percent of former foster youth are homeless for at least one night after they leave foster care.

The need for safe, affordable housing is a central need identified by young adults who have aged out of substitute care. These young adults need to have transitional housing with supportive services, rental vouchers with supportive services, and affordable housing.

In 2002, the Casey Family Programs Foundations for the Future released a framework for youth transitioning from foster care to successful adulthood. It mentioned finding and maintaining good living situations as one of the biggest challenges for youth leaving foster care. The framework for housing includes:

- Provide life skills classes that teach youth how to live independently.
- Provide opportunities for youth to practice living on their own.
- Increase staff knowledge of housing issues, including knowledge of available resources to accommodate housing needs.
- Create alliances with housing providers.
- Ensure that youth have a safe, affordable place to live when leaving care.

In 2002, the Jim Casey Youth Opportunities Initiative sponsored a study exploring public knowledge and perceptions about the challenges facing youth leaving foster care. The main findings of the study were:

- The majority of Americans say they know little about the foster care system and the issues facing its alumni. Americans also have mixed feelings about how well the foster care system serves those in its care.
- Most Americans agree that age 18 is too young for people (including either youth leaving foster care or other youth) to be completely on their own. Most appreciate the unique challenges that foster care alumni face in their transition to adulthood.
- Americans believe it is important to provide assistance to those aging out of foster care.

Legislation. The national IV-E Independent Living Skills Initiative of 1986 responded to concerns about the poor outcomes of youth emancipating out of foster care. The 1986 law and subsequent amendments provide for emancipation skills training to youth in foster care and post-foster care up to age 21. The Foster Care Independence Act of 1999 (FCIA) established the John H. Chafee Foster Care Independence Program and was passed to strengthen states' capacity to deliver independent living services to foster, independent and former foster youth. The legislation:

- Doubled Federal funding for the Independent Living Program to $140 million per year.
- Required states to use some portion of their funds for assistance and services for older youths who have left foster care but have not reached age 21.
- Allowed states to use up to 30 percent of their Independent Living Program funds for room and board for youth's ages 18 to 21 who have left foster care.
- Allowed states to extend Medicaid to 18, 19, and 20-year olds who have been emancipated from foster care.

The Governor's Commission on Home and Community-Based Services released a report June 2003 discussing the many barriers and actions steps needed to shift the balance of long-term care services in Indiana. Twenty-eight Actions were presented to serve as a blueprint for reform in Indiana. Two of the Actions focused on children at-risk and are as follows:

- The Family and Social Services Administration should assist each Indiana community to implement an integrated and unified system of care that is organized to respond to the needs of children who are at-risk of long-term out of home placements. A system of care is a "comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of individuals and their families.

- The Governor must issues a clear statement that identifies an on-going commitment by the State of Indiana to early identification and assessment of children who need services as well as a comprehensive prevention and early intervention strategy for Hoosier children.

Resources. The types of resources available to individuals who are transitioning out of foster care in Indiana include the following:

- Young adults, 18-20 years of age, voluntarily receiving independent living services, must undergo Energy Education Training. The training covers such topics as, overall home energy use, space heating, adjusting thermostats, water heating, hot water heaters, lighting appliances, and heating leaky space. In addition to each training, each youth also is given an Energy Conservation Kit that includes such items as, an energy efficient shower head, faucet aerators, compact fluorescent light bulbs, and a Conservation Action Kit booklet to guide the young adults though the installation and assessment of energy savings potential.

- Emancipation Kits (including items, such as a tool kit, towels, pot and pans, etc.) are given to youth aging out of the foster care system. A Resource Card, listing important telephone numbers of agencies is also given to youth upon discharge from care. Helpful numbers listed on the laminated card include, the Family Helpline, FSSA General information, Runaway National Switchboard, Indiana Workforce Development and many others.

- Agencies providing housing services, either directly or by referral, include:
  - education regarding the range of housing options, budgeting for consistent payments of rent to assure a positive rental history;
  - education on tenant rights and responsibilities;
  - education to develop understanding of the importance of following apartment communities rules and regulations policies;
  - advocacy on behalf of youth for affordable appropriate housing;
  - assistance with obtaining safe, growth enhancing living environment suitable to the needs of the youth and his/her level of functioning; and
  - receives formal supervised independent living services where the youth is under the supervision of an agency and receiving agency financial support, but without 24-hour adult supervision, as appropriate and outlined in the case plan.

- Each year workshops and youth conferences are held throughout the state for the youth. Two computer workshops are held to increase self sufficiency. Upon successful completion, the youth leaves with the computer, printer, software, power strip, and text book. There are also two youth conferences held each year discussing employment services, housing, post secondary and training opportunities, budgeting and living independently.

- HUD's Family Unification Program (FUP), managed by the Indiana Family Social Services Administration, provides housing assistance for youth ages 16 to 21 who have left foster care at age 16 or older. These vouchers are time-limited so that a youth can only have the voucher for 18 months. The agency that refers a youth to this program provides aftercare to each youth when they enter housing using a voucher. There are an array of services available to youth in housing to promote their successful transition to adulthood.

- The Transitional Living Program is a part of the U.S. Department of Health and Human Services Family and Youth Services Bureau's Runaway and Homeless Youth Program. The TLP provided funding to the Children's Campus, Inc in Mishawaka. The Children's Campus treats severely emotionally disturbed children, adolescents and their families who require compassionate and specialized care, in residential environments ranging from secure care to independent living.

- There are 6 youth shelters in Indiana for persons 17 years and younger throughout the State. In Indiana persons 18 years and over are considered an adult and can receive services at any shelter for adults. IHFA has given three awards for youth shelters for a total allocation of $980,000. The awards were made to the following counties:

  - Harrison County was awarded $200,000 in CDBG funds in January 2004 for 10 units of a youth shelter;
  - The Bashor Home in Elkhart County was awarded $480,000 in January 1999 to provide permanent housing to children under the age of 21 that are either wards of the State or homeless; and
  - Dearborn County was awarded $300,000 in November 1998 for rehabilitation of a youth shelter.

- Indiana is using the John H. Chafee Foster Care Independence Program funding for Room and Board, Independent Skill Services and Youth Advisory Boards for youth ages 14 to 21 who are transitioning from foster care. Services are available based on availability of funding in each county. All 92 counties have included IL services in their budgets to manage the 20 percent match but all have limited funds. Youth that will age out will most likely take priority over those that do not but are still eligible for services. Except for Room and Board, IL skill services are available to youth that were in foster care at any time after the age of 14 and probation youth that were in foster care after that age of 14 and were IV-E eligible. Room and Board services have been capped at $3,00 per eligible youth between age 18 and 21. When youth receive Room and Board services, it is expected that the youth will be capable of becoming self-sufficient within a 6 month period with skill services being provided also. The Chafee allotment for Indiana was $2,184,711in 2004 and is distributed by the Division of Family and Children.

- The Education and Training Voucher Program (ETV) is a recent federal program offering financial assistance, up to $5,000 per year not to exceed the cost of attendance, to eligible Indiana youths to help with post secondary education (college) or job

training. The U.S. Department of Health & Human Services awarded the State of Indiana $712,952 in 2004 and is distributed by the Division of Family and Children.

The Elderly

Total population. According to 2002 U.S. Census population estimates, there were 757,451 persons over the age of 65 living in Indiana in 2002, a 0.6 percent increase over the 2000 total of 752,831. According to commerce data forecast, the State's elderly population is expected to grow to 760,728 in 2005 and 809,460 in 2010, a 6.9 percent increase from 2002. The elderly made up 12.3 percent of the State's population in 2002; by 2010 this is expected to increase slightly to 12.6 percent. Nationally, the elderly constituted 12.3 percent of the total population in 2002, but this share is projected to increase to 20 percent by 2030 as the baby boomers continue to age.

Housing. According to the 2000 Census, 50,034 seniors, or 6.6 percent of the State's elderly population, lived in group quarters, nursing homes included. This is nearly one percentage point higher than the 5.7 percent of seniors nationwide living in group quarters. Nationally, about 4.5 percent of the 65 and older population lived in nursing homes in 2000, with percentages increasing dramatically with age.[1] For example, only 1.1 percent of those aged 65 to 74 nationwide lived in nursing homes in 2000, while 4.7 percent among those aged 75 to 84 years and 18.2 percent of those 85 years and older lived in nursing homes.

Of the seniors residing in group quarters in Indiana, 44,402 lived in nursing homes and the majority of the remaining 5,632 lived in noninstitutionalized group housing. This noninstitutionalized housing most likely represents the less intensive steps in the housing continuum (i.e., congregate care and assisted living).

Of the remaining senior households in Indiana, 79 percent owned their homes in 2000. This was similar to nationwide statistics that showed 78 percent of older residents owning their homes. For individuals 85 years and older, the State homeownership rate dropped to 66 percent, which was slightly higher than the nation (65 percent). Nonetheless, declining homeownership is indicative of both increasing needs for assisted living and the difficulty supporting the burden of homeownership as individuals age. Exhibit V-1 below presents the housing situations of the senior populations in Indiana and the U.S.

Exhibit V-1.
Senior Housing In the State of Indiana and the United States, 2000

Note:
Group home figures represent individuals while renter and owner figures are households.

Source:
U.S. Census Bureau, 2000 Census.

Housing Type	State of Indiana	United States
Group quarters population	50,034	1,993,621
Nursing homes	44,402	1,557,800
Other institutionalized	1,478	83,276
Non-institutionalized	4,154	352,545
Owner-occupied households	395,565	17,553,827
Renter-occupied households	102,486	5,080,863

[1] U.S. Census Bureau, "The 65 Years and Over Population: 2000 Census, Census 2000 Brief, October 2001," http://www.census.gov/prod/2001pubs/c2kbr01-10.pdf.

Among family households, the proportion of seniors owning their homes is higher, because the figures exclude seniors living alone and those residing in group quarters, such as nursing homes or assisted living facilities. Exhibit V-2 below displays the tenure of seniors by family type.

Exhibit V-2.
Elderly Families by Tenure, Type and Age, March 2000

Family Type and Tenure	65 to 74 Years	Percent 65 to 74 Years	75 Years and Over	Percent 75 Years and Over
Total Families				
Owner Occupied	146,217	32.0%	89,771	88.5%
Renter Occupied	12,642	8.0%	11,656	11.5%
Married Couple Families				
Owner Occupied	127,447	93.9%	71,404	89.8%
Renter Occupied	8,334	6.1%	8,095	10.2%
Male Householder, No Spouse Present				
Owner Occupied	3,581	82.0%	3,628	88.7%
Renter Occupied	788	18.0%	463	11.3%
Female Householder, No Spouse Present				
Owner Occupied	15,189	81.2%	14,739	82.6%
Renter Occupied	3,520	18.8%	3,098	17.4%

Note: The data in this table do not include individuals in group quarters.
Source: U.S. Bureau of the Census, 2000 Census.

Exhibit V-3 on the following page presents the tenure of seniors in non-family households.

Exhibit V-3.
Non-family Elderly by Tenure, Type and Age, 2000

Non-family Household Type and Tenure	65 to 74 Years	Percent 65 to 74 Years	75 Years and Over	Percent 75 Years and Over
Total Non-family Households				
Owner Occupied	68,372	69.8%	91,205	65.2%
Renter Occupied	29,547	30.2%	48,641	34.8%
Male Householder Living Alone				
Owner Occupied	16,448	67.1%	18,596	70.8%
Renter Occupied	8,079	32.9%	7,656	29.2%
Male Householder Not Living Alone				
Owner Occupied	2,072	76.6%	952	76.2%
Renter Occupied	633	23.4%	297	23.8%
Female Householder Living Alone				
Owner Occupied	48,088	70.3%	70,410	63.6%
Renter Occupied	20,362	29.7%	40,349	36.4%
Female Householder Not Living Alone				
Owner Occupied	1,764	78.9%	1,247	78.6%
Renter Occupied	473	21.1%	339	21.4%

Note: The data in this table do not include individuals in group quarters.
Source: U.S. Census Bureau, 2000 Census.

There is an increasing likelihood that seniors, particularly women, will live alone as they age. This is due in large part to the longer life expectancies of women. As shown in the data above, the majority of seniors in nonfamily households live alone. In 2000, of the elderly population aged 65 to 74 and living alone, 26 percent were male and 74 percent were female. This share increases for seniors age 75 and older, to 19 percent of males and 81percent of females living alone.

In most circumstances, seniors prefer to stay in their own homes as long as they can. If they are nearby, family members can assist with basic care needs, which enables seniors to remain in their homes longer than they would otherwise. However, the heavier work demands placed on many individuals and increased transience of the population in general in recent years has made family assistance more challenging.

Outstanding need. Elderly individuals face a wide range of housing issues, including substandard housing, a need for modifications due to physical disabilities and a lack of affordable housing.

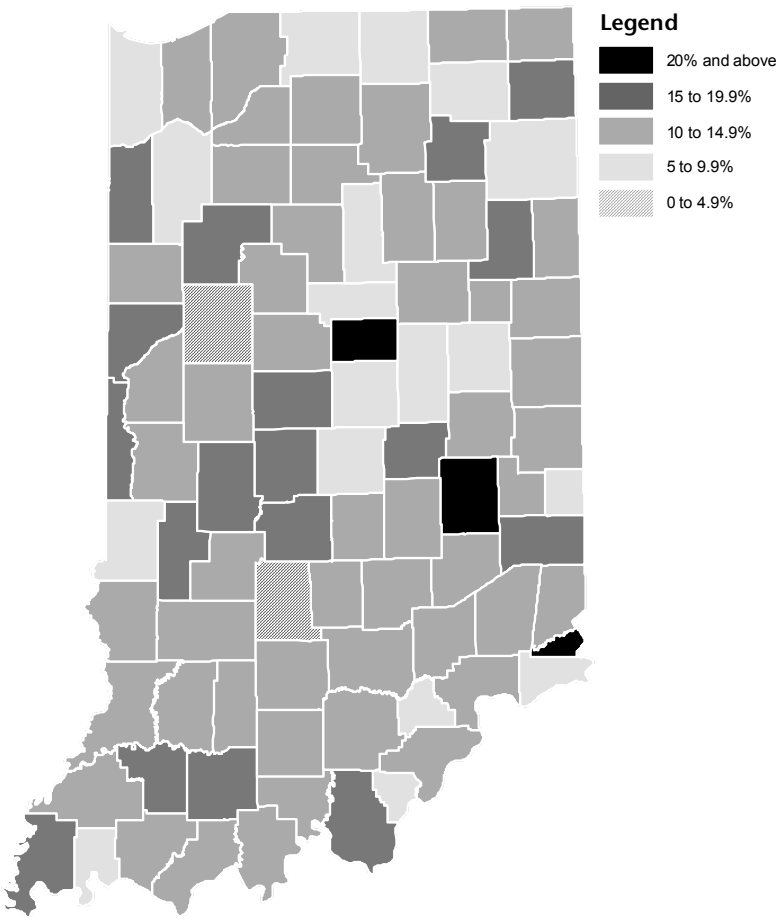
HUD's 1999 Housing Our Elders Report provides the latest national data available on seniors living in housing in need of repair or rehabilitation. HUD reports that in 1999, 6 percent of seniors nationwide lived in housing that needed repair or rehabilitation. Applying this estimate to Indiana, it is estimated that approximately 27,000 elderly residents of nonentitlement areas in Indiana were likely to live in substandard housing in 2000.

Many seniors also live in-homes that need modifications to better serve their physical disabilities or other mobility limitations. This trend is reflected by the 33 percent of seniors age 65 to 74 who indicated disability status in the 2000 Census. The percentage rises dramatically to 54 percent of seniors age 75 years and older. Seniors who indicated disability status had a sensory, physical, self-care, going-outside-the-home or employment disability.

Compounding the needs some seniors face for repair or improvements are the low and/or fixed incomes they have available to make those changes. The U.S. Census Bureau uses a set of income thresholds that vary by family size and composition to determine who is poor. The elderly poverty rate in Indiana, those over the age of 65 whose total income was less than the threshold, was 7.2 percent in 2000. Of the 54,287 elderly in poverty as of the 2000 Census, 801 (or 1.5 percent) were male householders with no wife present and 3,724 (or 6.9 percent) were female householders with no husband present. Exhibit V-4 below displays the percentage of seniors 65 years and older below the poverty level by county.

Exhibit V-4.
Percentage of Seniors 65 years and over Below Poverty Level, 2000

Source:
U.S. Census Bureau, 2000 Census.



In 1999, over 52,500 elderly households had incomes of less than $15,000 and an additional 54,000 had incomes ranging from $15,000 to $24,999. Exhibit V-5 on the following page illustrates the historical and estimated income distribution of elderly households in Indiana in 1990 and 1999.

Exhibit V-5.
Household Income Distribution of Indiana's Elderly, 1990 and 2000

Households by Income	1990 Number	1990 Percent	2000 Number	2000 Percent	Percent Change 1990 to 2000
Householders 65 to 74 yrs					
Less than $10,000	60,219	23%	26,400	10%	-56%
$10,000 to $14,999	41,341	16%	26,135	10%	-37%
$15,000 to $24,999	70,340	27%	53,974	21%	-23%
$25,000 to $34,999	40,544	15%	45,146	18%	11%
$35,000 to $49,999	28,818	11%	44,772	18%	55%
$50,000 to $74,999	15,432	6%	32,901	13%	113%
$75,000 to $99,999	4,069	1%	12,182	5%	199%
$100,000 and over	3,905	1%	13,539	5%	247%
Householders 75 yrs & over					
Less than $10,000	73,963	39%	38,320	16%	-48%
$10,000 to $14,999	35,343	19%	41,368	18%	17%
$15,000 to $24,999	40,886	21%	59,636	25%	46%
$25,000 to $34,999	18,841	10%	36,501	16%	94%
$35,000 to $49,999	11,706	6%	26,956	11%	130%
$50,000 to $74,999	6,413	3%	17,911	8%	179%
$75,000 to $99,999	1,855	1%	6,394	3%	245%
$100,000 and over	1,899	1%	7,390	3%	289%

Note: Household income does not include the value of property.
Source: U.S. Census Bureau, 1990 and 2000 Census.

Households paying more than 30 percent of their income for housing are often categorized as cost-burdened. Data from the 2000 Census indicate that 17 percent of homeowners 65 to 74 years and 18 percent of homeowners 75 years and older are cost-burdened. This statistic increases with seniors who are renters; in 2000, 45 percent of renters 65 to 74 years and 53 percent of renters 75 years and older were cost-burdened.

Resources. Given the variety of housing options available to serve the elderly, and the fact that much of this housing is privately produced, it is difficult to assess the sufficiency of housing for the State's elderly households without undertaking a comprehensive market analysis. However, the same housing problems that exist for the elderly nationwide are also prevalent in Indiana. The most pressing issues for middle- and high- income elderly in the U.S. are finding facilities located in areas they prefer to live, with access to public transit and other needed community services. For low-income elderly, the most difficult issue is finding affordable housing with an adequate level of care.

Numerous federal programs, although not targeted specifically to the elderly, can be used to produce or subsidize affordable elderly housing. These include CDBG, HOME, Section 8, Low-Income Housing Tax Credits, mortgage revenue bonds and credit certificates and public housing. There are also several federal programs targeted specifically at the elderly. Although many of these programs are meant to serve a great need in the U.S. — housing the low-income elderly — they often fall short in providing adequate care and other needed services. A description of the programs widely available to the elderly in the State, along with the utilization of the programs, follows.

Section 202 housing. Section 202 is a federal program that subsidizes the development of affordable housing units specifically for elderly. The program might also provide rental subsidies for housing developments to help make them affordable to their tenants. The developments often provide supportive services such as meals, transportation and accommodations for physical disabilities. The units are targeted to very low-income elderly and the disabled. The Section 202 program has supported over 300,000 units in over 3,500 housing developments nationwide since 1959. Funding from the FY2003 appropriations anticipate the creation of approximately 6,000 new housing units for low-income elderly.[2]

Equity conversion. The Home Equity Conversion Mortgage Program (HECM) supports repair and rehabilitation of housing and the ongoing needs of individuals by allowing elderly homeowners to recapture some of the equity they have in their homes through reverse mortgage programs. Individuals who own their homes free and clear, or have very low outstanding balances on their mortgages, are eligible for the program as long as they live in their homes. The HECM became a permanent HUD program in 1998.

As of December 2003, more than 80,000 elderly homeowners have chosen HECM loans to help them with their financial needs. Lenders originated a record 18,097 HECM loans during the federal fiscal year (FY2003) ending September 30, a 39 percent increase over the 13,049 loans closed the previous year. The increase in loans was driven by record low interest rates that reduced monthly income to seniors from CDs and similar investments, plus other factors. Also affecting HECM loans is the announcement that as of January 2004, seniors will be able to qualify for larger reverse mortgages due to new higher loan limits. The loan limit increase will enable seniors to convert a greater portion of the equity in their homes into cash to address their financial needs through retirement.

A study of the HECM program, conducted in March 2000 found the following trends:

- HECM borrowers tend to be older and are more likely to be single female households;
- HECM properties are more valuable and owners have a higher equity share;
- HECM properties have a higher share in the West and Northeast regions of the country;
- The program is increasingly located in the center city; and
- Highest penetration is in Utah, Colorado, the District of Colombia and Rhode Island.

Specifically in Indiana, the study found that HECM loans grew 611 percent from 76 loans in 1995 to 540 loans in 1999. Overall, 694 HECM loans had been originated in Indiana by October 1999.

In May 2003 an update to the 2000 report was completed to address several issues that may be inhibiting the reverse mortgage market in general and the HECM market in particular. The report updated the actuarial analysis presented in the 2000 HECM report and examined the potential impact of three legislated changes to FHA's Home Equity Conversion Mortgage Program.

[2] "Section 202 Elderly Housing." Coalition on Human Needs. http://www.chn.org/issues/article.asp?Art=330

There are 36 entities in the State of Indiana that are HUD approved mortgage counselors for the HECM program and eight HUD approved lenders.[3] The counseling agencies have offices throughout the State and are generally accessible to most citizens. The lenders are located in Indianapolis, Carmel, Granger, Jasper, Schrereville, Merrillville and Munster which could limit access to the program for some elderly individuals.

Rural home improvement. The United States Department of Agriculture, through its Rural Housing Service, offers loans of up to $20,000 with very favorable repayment terms (currently one percent with a 20 year term) to very low-income rural residents with housing repair needs. Grants up to $7,500 are also available for very low-income rural residents who are 62 years and older and do not have sufficient funds to repay the rehabilitation loans offered.

Medicaid. Another important federal support for elderly housing is the Medicaid program. Typically, Medicaid is used to pay for room and board in nursing homes or other institutional settings. States can seek approval from the Centers for Medicare & Medicaid Services (CMS), previously named Health Care Financing Administration (HCFA), to allow Medicaid to be applied to in-home services and services (but not rents) of assisted living facilities.

Currently in Indiana, Medicaid can be used for in-home services for the elderly and disabled in cases where without the services, an individual would need to be institutionalized. Medicaid waivers can also be used to pay for "environmental modifications" to the homes of elderly or disabled individuals. The State recently received approval from CMS to be able to use Medicaid for assisted living services. In October 2004, the State received a grant of $500,000 to enhance community-based services for senior citizens and people with disabilities. During 2002 and 2003, Indiana's Family & Social Services Administration (FSSA) helped create options for more than 4,800 seniors and 2,000 people with disabilities to live in their homes and communities. In the next two years, FSSA plans to help create options for 1,000 more seniors and 1,000 more people with disabilities.

Individuals apply for a Medicaid waiver through their local Area Agency on Aging offices, Vocational Rehabilitation offices, Bureau of Developmental Disabilities Services field offices, and/or Division of Family and Children offices. The lifetime cap for use of Medicaid waivers is currently $15,000 for disabled individuals and the elderly.

CHOICE. The State of Indiana offers a home health care program (Community and Home Options to Institutional Care for the Elderly and Disabled, or CHOICE) which provides a variety of services to the elderly, including minor home modifications. The goal of the program is to enable the elderly and persons with disabilities to live independently. Similar to the Medicaid waivers, individuals apply for the program through Area Agencies on Aging. (In fact, the State has combined funding from the various State and federal programs that fund services for the elderly and disabled into a bundled program that provides "one stop shopping" for the elderly and disabled). There is currently a $5,000 lifetime limit for Medicaid funding of CHOICE services for the elderly.

[3] The list is limited to Lenders who have done a HECM within the past 12 months, as of March 2004.

In FY 2002, 12,728 Indiana residents benefited from the CHOICE program. The original projections of use of the CHOICE program were far exceeded. Between 1998 and 2002, the number directly served by CHOICE increased by nearly 28 percent. In FY 2002 there were 8,577 people on the waiting list to receive CHOICE services, which is approximately a three to four month wait from the first date of contact.

A 2002 analysis of CHOICE beneficiaries found that approximately 80 percent of those served were 60 years and over and 20 percent were persons with disabilities only (not 60 years and over). Individuals 85 and over accounted for 27 percent of all CHOICE beneficiaries. Most CHOICE recipients lived alone and had incomes of less than $10,000 per year.

Home modifications. Funding for home modification projects is available to owner occupied households through IHFA's Housing from Shelters to Homeownership program, which uses HOME and CDBG. The Governor's Planning Council for People with Disabilities (GPCPD) recently completed a survey of the scope, status and character of home modification services in Indiana with a grant from IHFA.

Developed by the Indiana Institute on Disability and Community (Center on Aging and Community), the primarily web-based survey was conducted from November 11, 2002 to January 12, 2003. Forty-five organizations providing services in 91 of Indiana's 92 counties responded to the extensive questionnaire. One hundred fifty individuals completed a second survey of 1,700 professionals in the building and trades industry. The results of both surveys were consolidated and interpreted in a final report published April 2003.

Exhibit V-6 presents the current status and future trends of home modification and proposed changes to public policy and programs to better accommodate needs of Hoosiers as derived from the survey and interviews with service providers.

Exhibit V-6.
Results of Indiana Home Modification Survey

Current State of Home Modification in Indiana
■ A wide range of non-profit and for-profit providers, varying in size and organizational base, provides home modification services in Indiana.
■ Home modification services are not equally available to consumers throughout the regions of the state.
■ Medicaid, Medicaid waiver, private pay and CHOICE are the most frequently utilized sources of funding for home modification services in Indiana.
■ Housing rehabilitation funding sources of federal origin are significantly underutilized for specialized home modification services.
■ Successful home modification programs depend upon a creative blending of funds from effective collaboration with multiple players, including local grass-roots and faith-based organizations.

Current State of Home Modification in Indiana (continued)

- Home modification services are needed and utilized by a broad population across the lifespan, from one to multi-person households, with very low to moderately high income.
- The large majority of home modification services target owner-occupied homes and not rental households.
- In-home assessments for home modification are highly non-standardized throughout Indiana and draw upon a wide range of disciplines and professions.
- Home modification providers regularly supplement their services with education for individuals, communities and other professions.

Future Trends and Barriers to Development

- The demand for home modification services in Indiana is increasing while the funding base is decreasing or, at best, remaining stable.
- The greatest barriers to the delivery of public home modification services to Indiana residents include lack of public funding, overly burdensome administrative requirements of funding sources, and lack of consumer information.
- Local public home modification programs have created some innovative response to cope with barriers and expand services.
- Home modification for private households is still rarely accomplished. Only 30 percent of private industry respondents provide accessibility features often or very often in their work.
- The large majority of private industry respondent (66 percent) have never received specialized training in areas related to home modification.
- A significant number of private industry respondents (58 percent) seek further education about home modification.

Program and Policy Recommendations

Based on the previous observations, a number of recommendations are offered to help improve the status of home modification services in Indiana and enable more Hoosiers to become and/or remain independent in their homes and active in their neighborhoods and communities.

- Public home modification services should be supported to network with one another to share best practices and collectively advocate for greater awareness of their needs and capacities.

Program and Policy Recommendations (continued)

- State and local housing and housing rehabilitation funding sources should contribute to the expansion of services through developing categorical grants for accessibility and visibility improvements to agencies that do not provide comprehensive housing development.
- Training for professionals involved with the home modification industry, both public and private, should be greatly expanded. The training should provide certification in accessibility specialties and include information to enable the effective utilization of public funding sources by private providers.
- Administrative requirements for private providers to access public funding should be streamlined and made user-friendly, with reimbursements provided on a timely basis.
- The home modification movement in Indiana should be supported to create local or regional "staying put" coalitions to build community capacity and expand awareness among consumers, policy makers, the building and trades industry and the general public.

Source: Home Modification Services in Indiana: Statewide Survey Results and Recommendation for Public Policy and Programs, April 2003.

Since the survey results and policy recommendations were published, IHFA and the Indiana Governor's Planning Council for People with Disabilities have organized training workshops for builders and trades people, home designers care givers, and others who deal with home modification in their work. The trainings are scheduled to begin in March 2004. A luncheon is also planned during the day of the workshops for workshop participants and others who want to know more about home modification.

Persons Experiencing Homelessness

Definition. The Stewart B. McKinney Homelessness Act defines a person experiencing homelessness as "one who lacks a fixed permanent nighttime residence or whose nighttime residence is a temporary shelter, welfare hotel or any public or private place not designated as sleeping accommodations for human beings." It is important to note that this definition includes those who move in with friends or relatives on a temporary basis as well as the more visible homeless in shelters or on the streets.

HUD's definition of homelessness is slightly more comprehensive. In addition to defining individuals and families sleeping in areas "not meant for human habitation," the definition includes persons who:

- "Are living in transitional or supportive housing for homeless persons but originally came from streets or emergency shelters;
- Ordinarily sleep in transitional or supportive housing for homeless persons but are spending a short time (30 consecutive days or less) in a hospital or other institution;

- Are being evicted within a week from private dwelling units and no subsequent residences have been identified and they lack resources and supportive networks needed to obtain access to housing; or

- Are being discharged within a week from institutions in which they have been residents for more than 30 consecutive days and no subsequent residences have been identified and they lack the resources and support networks needed to obtain access to housing."

This definition demonstrates the diversity of people experiencing homelessness. The numerous locations in which people experiencing homelessness can be found complicates efforts to estimate an accurate number of the population.

Total population. Estimating the total population of persons experiencing homelessness on a nationwide, Statewide or even local level, is challenging because of the various types of homelessness and difficulty in locating the population. For example, an individual living with friends on a temporary basis can be considered homeless but would be unlikely to be identified in a homeless count.

The most recent and comprehensive count of persons experiencing homelessness anywhere in the State was conducted in Indianapolis during 1999 and 2000 by the Coalition for Homelessness Intervention and Prevention (CHIP). The survey found that an estimated 12,500 to 15,000 people in Indianapolis experience homelessness during one year. If this incidence of homelessness is applied Statewide, it can be estimated that approximately 100,000 Hoosiers have experienced homelessness over the period of one year.

The 2003 State Continuum of Care application estimated a total of 15,178 persons experiencing homelessness in the State. This number is lower because it is a point-in-time count, which differs from the "over the year" estimate from the CHIP survey. The point-in-time survey was conducted on June 26, 2003 and was done via the internet. Indiana Coalition on Housing and Homeless Issues (ICHHI) reviewed the data and compared it against population estimates provided by the U.S. Census Bureau. Through this comparison, ICHHI was able to determine the number of emergency and transitional housing beds per capita, and the percentage of the general population that received shelter.

The Continuum estimated a need for 5,813 beds or units for persons experiencing homelessness in Indiana, which exceeds the current and under development supply by nearly 3,226. After adjusting for beds per capita, if was found that 0.21 percent of the general population were homeless at the point-in-time. This number translates to 9,345 persons needing some type of shelter per night. This number correlates well with the City of Indianapolis, who has estimated nearly 3,500 homeless persons per night in their own CoC. Additionally, if one percent of the populations is homeless during the year and 10 percent of the homeless is chronically homeless, then there is a large undercount of chronically homeless persons and persons in need of Permanent Supportive Housing.

The Census provides a point-in-time estimate of the number of people in emergency and transitional shelters as identified by group quarters.[4] However, the Census stresses that these data do not constitute and should not be construed as a count of people without conventional housing as the tabulation is not comprehensive.

This count only includes people without conventional housing who stayed overnight in permanent and emergency housing, missions, Salvation Army shelters, transitional shelters, hotels and motels used to shelter people without conventional housing and similar places known to have people without conventional housing staying overnight. On March 27, 2000, the Census identified approximately 2,384 persons staying in emergency and transitional shelters of this type Statewide. Of these persons, 63 percent were male and 26 percent were under 18 years of age.

Another way to estimate the number of persons experiencing homelessness is by using counts of the number of persons experiencing homelessness served by State and local assistance. The Family and Social Services Agency (FSSA) reported serving 3,244 persons experiencing homelessness in FY2003. Of these persons, 315 were located in rural areas and 2,929 were in urban areas.

When assessing the extent of homelessness in nonentitlement areas, it is important to note the degree to which it may be hidden. That is, in areas where there are limited social service providers, it might be more common for those at risk of experiencing homelessness to move in with friends and relatives rather than to seek local services or housing at a shelter. Furthermore, when individuals have exhausted all other alternatives, they are likely to move to larger cities with institutional supports such as homeless shelters and soup kitchens. This progression makes it difficult to detect the extent of homelessness in nonentitlement areas.

If the number of persons staying in shelters during the 2000 Census count represents just two percent of the State's homeless population, this would suggest a total population of 119,200 persons who are homeless.

The study conducted by CHIP further illustrates this point. It found that only 2 percent of the general population said they would go to a shelter or the street if they lost their home, which implies that 98 percent of people considered homeless by definition are not in shelters or on the street. The study also indicated that over 110,000 Indianapolis residents, or about 7 percent of the population, were temporarily homeless and relying on relatives for housing in the past year. If this figure is applied to Statewide population statistics, approximately 400,000 Indiana residents defined as homeless were staying with friends or relatives at one point over the year. These people are considered to be the hidden homeless.

[4] Census 2000 PHC-T-12. Population in Emergency and Transitional Shelters, http://www.census.gov/population/cen2000/phc-t12/phc-t12.pdf.

Characteristics of persons experiencing homelessness. While the only consistent characteristic of persons experiencing homelessness is the lack of a permanent place to sleep, there are a number of subgroups that are typically part of the homeless population. These include the following:

- **HIV/AIDS.** National estimates place the proportion of persons experiencing homelessness who are HIV positive at 15 percent. Other estimates place the total at between 1 and 7 percent. Providers of HIV/AIDS services in Indiana believe the actual count is closer to the national figure.
- **Substance abuse.** A recent HUD report found that 38 percent of individuals experiencing homelessness who contact shelters, food pantries or other assistance providers have an alcohol dependence, 26 percent have a drug dependence and 7 percent have both. Applying these percentages to the estimate of the 100,000 persons experiencing homelessness in the State during any one year results in a total of approximately 71,000 individuals experiencing homelessness who also have substance dependencies.
- **Mentally ill.** CHIP's Indianapolis study indicated that approximately 30 percent of the single adult homeless population suffers from some form of severe and persistent mental illness. National estimates suggest this may be closer to 40 percent. Using the above estimate of 100,000 persons experiencing homelessness in Indiana over the course of a year, this would indicate that approximately 30,000 of those individuals have a mental illness.
- **Families.** The Blueprint to End Homelessness in Indianapolis reported 40 percent of the local homeless population are families in 2002. If the 40 percent rate was applied to the estimated 100,000 Hoosiers who have experienced homelessness during one year, it would mean 40,000 were families. Twenty years ago it was rare to find families who were homeless. Nationally, families comprise the fastest growing group of homeless people. The Blueprint also reported 4,500 children experience homelessness annually in Indianapolis. Homeless children are more likely to suffer from mental and physical health problems and they are at greater risk of failing in school.

At risk of experiencing homelessness. In addition to those who have experienced homelessness in the past or who show up on a point-in-time estimate of current homelessness, it is important for policymakers to know the size of the population that is at risk of future homelessness. In general, the population at risk of experiencing homelessness includes persons who are temporarily living with friends or relatives (also known as hidden homeless) and individuals at risk of losing their housing (usually very low-income).

The Indianapolis study of persons experiencing homelessness conducted by CHIP found that 69,000 Indianapolis residents reported that they were in danger of becoming homeless in the past year. Applying this number to Statewide population data, it is estimated that over 550,000 (or about 9 percent) of Indiana residents may have been in danger of experiencing homelessness in the past year. The share of the population that has very low-income or is severely cost-burdened (e.g., paying more than 50 percent of income in housing costs) is also useful in estimating the number of persons at risk of experiencing homelessness. The 2000 Census reports that 16 percent of all homeowners (220,000 households) in the State were paying more than 30 percent of 1999 household income for housing, and 11 percent (154,000 households) were paying more than 35 percent. The 2000 Census also

estimates that one-third of Indiana renters — or 218,000 — paid more than 30 percent of household income for gross rent, with most of these (26 percent of renters, or 172,000) paying more than 35 percent of their incomes. Rentals constitute only 26 percent of the State's occupied housing units in 2000; however, there were almost as many cost-burdened renter households (218,000) as cost-burdened owner households (220,000).

The Information & Referral Network received more than 10,000 people in 2003 requesting help with a housing issue. This represents 20 percent of all callers in 2003, a 24 percent increase in reported housing needs compared to 2002. The three largest needs in the housing category were those for rent/mortgage assistance, shelter and low-cost/subsidized housing. Rent/mortgage assistance accounted for 37 percent of all housing needs. Of the 4,086 rent requests, 3,847 (94 percent) were recorded as "unmet." This places these people at risk of becoming homeless if they are unable to pay their rent. FEMA money for rent assistance continues to be a very scarce resource. The only recourse for most people needing rent is top apply to their township trustee. Allocation amounts and eligibility requirements vary widely among trustees; most people needing help do not qualify for assistance. There are simply not enough financial resources in the community to meet this need.

An important factor in considering the number of households at risk for homelessness is that approximately 32,500 Section 8 units in Indiana are at risk of expiring and converting to market rate rents (see Section IV for details about expiring use units). According to the most recent national statistics, almost 10 percent of owners of expiring units have opted out, indicating that the State could likely lose up to 3,250 units of affordable housing. This does not mean that residents of expired units will completely lose access to subsidized housing. The residents of those units that are no longer available will receive vouchers to obtain another unit. Although vouchers have some advantages in that they allow recipients to move into areas of less concentrated poverty, mismatches between the amount of subsidy provided through vouchers do not guarantee adequate housing if the supply of units that accept vouchers is lacking. In many cases in Indiana, the subsidized rents of expiring use properties have been higher than local market rents. Although the outcomes of the expiring use conversions are property specific, conversions may provide tenants with opportunities for lower rents or units that better meet their needs.

Housing for homeless. According to the 2003 Continuum of Care, the State had a total of 2,239 beds/units available to individuals and 2,045 for person in families with children, who are homeless (excluding metropolitan areas).

Outstanding need. The 2003 Continuum of Care application estimated a need for a total of 4,910 beds or units for individuals and 5,500 beds or units for persons in families with children who are experiencing homelessness. State shelters will support a total of 2,365 beds/units for individuals and 2,232 for persons in families with children by the end of 2003. As seen in Exhibit V-7 (which is also HUD table 1A), this total still leaves unmet needs for all types of housing, totaling 2,545 beds or units needed for individuals and 3,268 beds or units for persons in families with children.

Exhibit V-7.
Housing Gap Analysis Chart, Indiana, 2003

Source:
2003 State of Indiana Continuum of Care, Application.

Beds	Current Inventory in 2003	Under Development in 2003	Unmet Need/Gap
Individuals:			
Emergency Shelter	975	40	485
Transitional Housing	434	8	558
Permanent Supportive Housing	830	78	1,502
Total (number of beds)	**2,239**	**126**	**2,545**
Persons in Families with Children:			
Emergency Shelter	798	39	663
Transitional Housing	703	98	699
Permanent Supportive Housing	544	50	1,906
Total (number of beds)	**2,045**	**187**	**3,268**

There are a total of 15,178 persons who are homeless. Approximately 54 percent are sheltered and the remaining 46 percent are unsheltered. The following exhibit shows the breakdown of homeless population and subpopulations and if they are sheltered or unsheltered.

Exhibit V-8.
Homeless Population and Subpopulations Chart, Indiana, 2003

Homeless Populations:	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Homeless Individuals	1,008	1,017	2,016	4,041
Homeless Families with Children	820	1,252	1,640	3,712
Persons in Homeless Families with Children	2,460	3,756	4,920	11,136
Total (number of persons)	**3,468**	**4,773**	**6,936**	**15,177**

Homeless Subpopulations:	Sheltered	Unsheltered	Total
Chronic Homelessness	935	639	1,574
Chronic Substance Abuse	2,803		
Persons with HIV/AIDS	475		
Seriously Mentally Ill	2,803		
Veterans	3,270		
Victims of Domestic Violence	2,366		
Youth	280		

Note: When determining the chronic homeless, the CoC used national statistics that state that at least 10 percent of the homeless population is considered homeless.

Source: 2003 State of Indiana Continuum of Care, Application.

The Continuum of Care has prioritized the projects it will fund in the 2003 application. The first project is for 20 units of permanent supportive housing. The second project is a renewal project of permanent housing to a targeted population of severely mentally ill (SMI) persons. The third priority project was to fund a transitional housing project that serves a targeted population of SMI.

The State's Continuum of Care notes that there are numerous barriers to ending chronic homeless. Examples of barriers include a lack of supportive services, shortages of matching funds and negative attitudes, i.e. "not in my backyard" (NIMBY). There are also many homeless service providers who believe that chronic homelessness is a much broader population than the current definition provided

by HUD. This may lead to resistance to addressing goals and objectives, as there is the perception that this policy may eventually pit large urban centers against smaller, rural areas, as the dollars tend to flow toward those with the highest numbers.

To combat these barriers, the State aims to create more permanent housing for chronically homeless persons, formulate a plan to end chronic homelessness, identify the extent of chronic homelessness, and and increase Community Mental Health Center (CMHC) and AIDS Service Organization (ASO) participation in serving chronically homeless.

Additionally, the State's Continuum of Care is in the process of implementing a Homeless Management Information System (HMIS). As of 2003, The Indianapolis Continuum of Care had 25 organizations linked through Client Track software and can exchange information regarding clients and delivered services. It is anticipated that the new system will more accurately reflect point-in-time counts over a greater period of time. The (Balance of) State's Continuum of Care is implementing AWARDS by Foothold Technology. [5]

In 2003, the Information & Referral Network responded to 2,713 calls from people needing shelter. This represents a 27 percent increase in the number of shelter calls compared to 2002 (2,128). There are 25 shelters in central Indiana that serve families, men and women in domestic violence situations. Despite existing resources, finding shelter space remains difficult. In fact the Information & Referral Specialists were unable to help 24 percent of those calling for shelter. Of those calling for shelter who also were in a domestic violence situation (14 percent of all shelter calls), 22 percent were unable to be immediately placed in shelter. The Emergency Bed Space Plan, operated by the Salvation Army shelter, is part of the Family Violence Community Wide Plan; it recently has been put into place to ensure that every domestic violence victim needing shelter has a place to stay. During extremely cold weather, the Winter Contingency Plan offers people a place to sleep for the night; aside from this resource (provided by 2 shelters in Marion County), many people must go without shelter due to limited capacity at existing shelters.

Resources. Indiana's strategy for meeting the needs of persons experiencing homelessness includes outreach/intake/assessment, emergency shelters, transitional housing, permanent housing and supportive services. The State employs a number of resources to support this strategy, including State agencies, regional planning commissions, county welfare planning councils, local continuum of care task forces, county step ahead councils, municipal governments and others.

In 2001, the State of Indiana Continuum of Care reorganized into a new planning body. Comprised of decision makers from various State agencies and the Indiana Coalition on Housing and Homeless Issues (ICHHI), the Indiana InterAgency Council for the Homeless was formed to provide better coordination and collaboration. The Council's sole purpose is to formulate Indiana's State response to homelessness. The Council established three subcommittees to provide specific recommendations

[5] The "State Continuum of Care" refers to all of Indiana except Evansville/Vanderburgh, Fort Wayne/Allen, South Bend/St. Joseph, and Indianapolis/Marion County. The Evansville, Fort Wayne, and South Bend Continua have also chosen Foothold Technology, which means all of Indiana will be using AWARDS except for Indianapolis.

to the Council: the Homeless Task Force, the Homeless Management Information Systems (HMIS) Task Force, and the Chronic Homelessness Policy Task Force.

Homeless Task Force. In 2003, the Indiana Homeless Task Force established a set of goals and timelines for addressing the needs of the homeless in the State. The goals are shown in Exhibit V-9 on the following two pages.

Exhibit V-9.
Homeless Task Force Goals and Timeline

Goals	Timeline	Status
1. Ensure homeless people receive mainstream resources for which they are qualified		
■ Review the application process for the various mainstream resources.	December 2002	FSSA has added language in their ESG 2004-06 application package offering points for providers to do this. Continue to focus on for 2004.
■ Identify barriers to homeless people accessing these resources.	December 2002	
■ Get feedback via ICHHI's website survey from homeless providers about problems that have encountered trying to help homeless people access mainstream resources.	December 2002	Completed.
■ Create a toolbox guide for homeless providers that lists all of the resources available to address the needs of the homeless, what the qualifications are, and how to apply for them.	*Project start date:* December 2002 *Toolbox guide:* March 2003	Continue to focus on for 2004.
2. Ensure State and local institutions do not discharge people into the homeless system.		
■ Review and evaluate the discharge policies of State run institutions.	November 2002	Completed. FSSA's Division of Mental Health reviewed and wrote a policy.
■ Identify where there is not a policy and where one should be developed.	November 2002	Completed.
■ Communicate the policies to homeless providers through the Continuum of Care regions and get feedback where policies are not being implemented.	November 2002	Ongoing. DMHA notified the providers.
■ Contact HUD to ensure we are interpreting the policy correctly regarding who should sign the discharge policy form in the Continuum of Care application.	January 2003	Ongoing.
■ Track individual progress through the system to determine if State and local institutions are complying.	July 2004	

Source: Homeless Task Force, Goals and Timeline, updated December 12, 2003.

Exhibit V-9.
Homeless Task Force Goals and Timeline (continued)

Goals	Timeline	Status
3. Improve the effectiveness of the regional Continuums of Care (CoC).		
■ Determine how we want the regions to report to the Task Force on their activities.	December 2002	Completed.
■ Develop a working model of how a regional CoC should function.	December 2002	Ongoing. Basic guidelines were completed but need to be further refined.
■ Identify a contact person for each region.	November 2002	Completed.
■ Provide two training sessions for the regions.	December 6, 2002 March 2003	Completed.
■ Hold Task Force meeting at one of the regional lead organization sites rather than Indianapolis.	April 2004	
4. Improve working relationship between mental health centers and homeless providers to ensure better access to services by mentally ill homeless persons.		
■ Survey mental health centers.	December 2002	Completed.
■ Develop model service agreement.	---	Ongoing.
■ Establish service agreements between at least 75percent of the mental health centers with homeless service providers.	May 2003	Ongoing. DMHA reported that many of the mental health centers have good verbal agreements in place with homeless service providers. DMHA is reviewing how these agreements are working out.
■ Highlight mental health centers that have established strong relationships with homeless service providers at the March 2003 training sessions.	March 2003	Ongoing. Did not do in 2003. The Task Force will include with 2004 CoC trainings.
5. Research sources to supplement Emergency Shelter Grant (ESG) funding for shelter operations.	Complete	Task Force will observe the progress of the legislature on the real estate transfer tax and update the Council on the outcome.

Source: Homeless Task Force, Goals and Timeline, updated December 12, 2003.

HMIS Task Force. The HMIS Task Force is charged with implementing the State's HMIS during 2003 and 2004. The HMIS will provide the State with much needed data about the number of persons who are homeless, the services they seek and need, and their housing patterns and needs. The Task Force has worked with entitlement communities in the State to ensure the systems are compatible Statewide. The State has secured two HUD Continuum of Care grants (one for $250,000 and a second for $800,000) to implement HMIS, and has negotiated the contract with Foothold Technology to implement HMIS.

The selection of the HMIS vendor was the final objective to be accomplished by the HMIS Task Force. Since the Task Force met all of its objectives, it decided to disband. The Indiana Coalition on Housing and Homeless Issues (ICHHI) will carry out future HMIS implementation efforts.

Two Continuum of Care Regions have been selected for Round One of HMIS user training. They are Region 4 (Greater Lafayette) and Region 6 (Greater Anderson/Muncie). The City of Evansville is a third pilot area. Round One of training is scheduled at the end of March 2004. Additional regions are scheduled to be brought online in June and September.

The objectives of the HMIS relevant to the Consolidated Planning process include:

- Identify and document an unduplicated count of the homeless in Indiana that entered the homeless system and accessed services;
- Serve as a unified intake system, track services received by clients, coordinate case management, and provide continuity of care to the clients;
- Determine shelter bed availability and other types of housing availability;
- Identify client needs and the gaps in services and housing to fill those needs; and
- Improve efficiency for services to the homeless.

Chronic Homelessness Policy Task Force. The Chronic Homelessness Policy Task Force was established in 2003. The Task Force is made up of State agencies, advocacy groups and homeless service providers. During this time, the Task Force has attended a HUD-sponsored Chronic Homeless Policy Academy, and is currently developing a *Statewide Action Plan for Ending Chronic Homelessness.* This strategy was developed in the Fall of 2003, and the draft strategies are currently being reviewed and edited. Some draft priorities include:

- Increases the supply of supportive housing;
- Enhance prevention activities and strategies;
- Enhance and coordinate support systems;
- Optimize use of existing mainstream resources; and
- Develop a policy and planning infrastructure.

Other activities. For the past several years, ICHHI, on behalf of the State through the Indiana Housing Finance Authority, has applied for HUD funding for Continuum of Care projects. In the 2002 SuperNOFA, 12 out of 12 Continuum of Care projects were funded, totaling nearly $5.25 million. The Continuum of Care has continued this momentum and applied for 22 projects in the 2003 application totaling over $9.8 million. These projects include transitional housing, permanent supportive housing, domestic violence shelters, and housing for special needs populations. In addition to the Continuum of Care funding, IHFA has a goal of dedicating $3.5 million annually for the development, construction, and/or rehabilitation of emergency shelters, transitional housing and youth shelters. IHFA also administers HOPWA funds, which are allocated each year based on regional needs. A large percentage of HOPWA funds generally go toward transitional housing programs and shelters. IDOC provides planning grants and infrastructure funds to homeless assistance providers.

Emergency Shelter Grant. FSSA administers the Emergency Shelter Grant (ESG) program, which funds emergency shelter and transitional services in shelters throughout the State. For the 2003 program year, the State of Indiana received an Emergency Shelter Grant of $1,747,000 to use for homeless shelter support, services and operations, homeless prevention activities and limited administrative costs.

As in past years, the State chose to allocate this funding to three primary activities: essential services, operations, and homelessness prevention activities. These types of activities are described below.

- **Essential services.** Essential services consist of supportive services provided by shelters for persons experiencing homelessness. These services vary, as they are tailored to client needs. In general, essential services consist of the following: employment services (job placement, job training and employment counseling), health care services (medical and psychological counseling, nutrition counseling and substance abuse treatment) and other services (assistance in locating permanent housing and income assistance, child care and transportation).

- **Shelter operations.** Funds allocated to shelter operations are used by shelters for operating and maintenance costs, shelter lease costs, capital expenses, payment of utilities, purchases of equipment and furnishings, provision of security, and purchase of food.

- **Homeless prevention.** The State believes in taking a proactive approach to the problem of homelessness. Once a person becomes homeless, it can be very difficult to move them back into permanent housing. The State assisted those at risk of experiencing homelessness through short-term rental and mortgage subsidies to prevent evictions or foreclosures, payment of apartment security deposits, mediation of landlord/tenant disputes and provision of legal services for tenants in eviction proceedings.

Shelter Plus Care. One goal of the State's FY2000 Consolidated Plan is to enhance resources such as FSSA's Shelter Plus Care grants that provide rental assistance for persons who are homeless *and* have a severe disability, including a serious mental illness. The State has successfully applied for and received two Shelter Plus Care grants from HUD. The first grant was awarded to Community Action of Northeast Indiana; it will provide $900,000 over 5 years to produce approximately 50 vouchers for housing and utility payments. Populations to be served include persons who are homeless and disabled and may have other special needs. The State recently received another Shelter Plus Care grant of $2.2 million. On April 28, 2003, FSSA held a statewide Shelter Plus Care training about the program and the additional funds.

Persons with Developmental Disabilities

Definition. According to the Indiana Bureau of Developmental Disabilities, three conditions govern whether a person is considered to have a developmental disability:

- Three substantial limitations out of the following categories: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living and economic self-sufficiency;
- Onset of these conditions prior to the age of 22; and
- A condition that is likely to continue indefinitely.

Total population. The Association of Rehabilitation Facilities of Indiana's 2000 Assessment of Developmental Disabilities Services estimates that 70,787 people in Indiana, or 1.2 percent of the State's population had a developmental disability in 2000. In 1995 the Governor's Council for People with Disabilities estimated the number to be 0.8 percent of the population, or about 48,000. Based on the 1.2 percent assumption, the total number of people in Indiana that have developmental disabilities is projected to grow to 74,055 in 2005. Approximately 65 percent of the 70,787 people with developmental disabilities had some degree of mental retardation, 9 percent had cerebral palsy, 17 percent had epilepsy and 10 percent had other physical and mental disabilities including autism.

Housing. There are a wide variety of housing options for persons with developmental disabilities in Indiana. These range from highly structured, institutionalized care to living in a community with various supportive services.

The trend away from large institutional settings for those with developmental disabilities is evident in the recent closures of such facilities as New Castle Developmental Center and Northern Indiana State Developmental Center. The State currently has two large developmental disability centers in Ft. Wayne and Muscatatuck. The Muscatatuck Development Center near Butlerville in Jennings County is scheduled to close in 2005. There are also three specialized hospital units (Madison, Logansport and Evansville) to serve persons with developmental disabilities. An additional ten large non-State institutions that house persons with developmental disabilities are located throughout Indiana.

The Homeless Task Force has also addressed the change from State institutions to smaller settings. One of their 2002 goals aims to ensure that State and local institutions do not discharge people into the homeless system. Objectives to obtain this goal are outlined in the second goal in Exhibit V-9. The Homeless Task Force learned of an Indiana Code requiring that residency must be considered in discharge planning. Currently, persons in developmental disability and mental health institutions that are being released cannot be released into homelessness. FSSA's Division of Mental Health has reviewed and written a policy concerning this issue, however many local institutions do not have formal written policies in place.

As the State has shifted away from institutional settings for people with developmental disabilities, the number of individuals served in smaller settings of six or fewer people (group homes, supervised apartments and supported living settings) has increased. According to the University of Minnesota's Institute of Community Integration, 3,957 of the total 7,989 persons served resided in settings of six or fewer persons as of June 30, 2002, which represents a 38 percent increase from 1995.

Exhibit V-10 below shows the number of facilities and residents in State-owned and non-State facilities, by size of facility for 2002. The number of facilities for 1 to 6 people has increased by almost 1,500 facilities since 2000. This reflects the trend away from large institutional setting for those in smaller community-based facilities.

Exhibit V-10.
Facilities and Residents in State and Non-State Facilities for Persons with Intellectual and Developmental Disabilities, June 30, 2002

	Number of Facilities			% change	Number of Residents			% change
	State	Non-State	Total	2000 to 2002	State	Non-State	Total	2000 to 2002
1 - 6 People	0	1,685	1,685 *	755%	0	3,957	3,957	282%
7 - 15 People	0	341	341	-3%	0	2,677	2,677	-3%
16+ People	6	7	13	-19%	640	715	1,355	-17%
Overall	6	2,033	2,039	262%	640	7,349	7,989	47%

Note: * Contains an estimate.

Source: Residential services for persons with developmental disabilities: Status and trends through 2002. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

As shown in Exhibit V-11 on the next page, the largest number of persons served in 2002 resided in congregate care facilities (4,981), followed by those living in their own homes or apartments (2,256), and those living with host families or in foster homes (782).

Exhibit V-11.
Residents by Type of Facility for People with Intellectual and Developmental Disabilities, 2000 and 2002

	2000	2002	Percent Change
Congregate Care	5,423	4,981	-8%
Host Family/Foster Home	490	782	60%
Homes Owned/Leased by Persons with ID/DD	1,447	2,256	56%
Subtotal	7,360	8,019	9%
Persons with ID/DD Receiving Services While Living With Family Member	1,358	2,256	66%
Total Services Recipients in Family Homes and Residential Settings	**8,718**	**10,275**	**18%**

Source: Residential services for persons with developmental disabilities: Status and trends through 2002. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

Outstanding need. There are a number of methods used when estimating the outstanding need of services for people with developmental disabilities in Indiana. Conservative estimates place the number of adults in need of services at 50 percent of the entire population with developmental disabilities. This estimate suggests that of the 70,000 individuals with developmental disabilities in Indiana, approximately 35,000 need services. According to the Governor's Planning Council on People with Disabilities, 12,000 individuals are currently receiving services, suggesting that approximately 23,000 of those who were estimated to need services are not receiving them.

A more conservative estimate can be reached by examining the waiting lists for various types of services. According to the *Residential Services for Persons with Development Disabilities: Status and Trends Through 2002* report there were 6,000 persons with developmental disabilities not receiving residential services who were on waiting lists for such services on June 30, 2002.

A critical need for people moving out of institutions is finding an alternative place to live. In 2000, 112 persons with developmental disabilities were discharged from State hospitals and institutions. These individuals likely faced housing needs upon discharge. Section 8 tenant-based vouchers remain the primary mainstream resource available for housing people with disabilities and will likely continue to be a critical source of housing subsidies.

In many communities, the rent burden for people with disabilities moving from institutional settings would be more than 50 percent of their monthly Supplemental Security Income (SSI) benefit. Data from the recent study *Priced Out in 2002* indicate that rental housing costs rose at twice the rate of SSI cost of living adjustments from 2000 to 2002. In Indiana, the monthly SSI benefit of $545 represents 16.6 percent of Statewide one-person median income. A person with disabilities receiving SSI income support in Indiana would have to pay 83.5 percent of this monthly benefit to be able to rent a modestly priced one-bedroom unit.

When considering future need it is important to note that the families and caregivers of persons with developmental disabilities are aging. Approximately 30 percent are 60 years and older and 40 percent are 40 years and older. As these primary caregivers become less able to care for their family members with developmental disabilities, alternative housing options will be needed. This could cause the needs for housing and other community resources to increase significantly in the next 10 to 15 years.

Resources. The types of support available to individuals with developmental disabilities in Indiana include the following:

- Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are large facilities or small group homes that provide intensive support services. A subset of these are Supervised Group Living (SGL) arrangements that provide 24 hour supervision overseen by paid staff in a home-like setting, which is often a single family dwelling.

- Nursing facilities are long-term health care facilities providing in-patient care and nursing services, restoration and rehabilitative care and assistance meeting daily living needs. Nursing facilities in Indiana served 1,933 individuals with mental retardation and related conditions in 2000.

- Through the State's Division of Disability Aging and Rehabilitation Services (DDARS), the Bureau of Developmental Disabilities Services (BDDS) administers several programs that assist individuals with developmental disabilities and their families, including:

  - Supported Group Living, which consists of homes with four to eight individuals residing in a group home. In 2001, 3,791 Indiana residents with developmental disabilities resided in SGL homes.

  - Supported Living, which consists of one to four individuals residing in a house or apartment with individualized supports. The former Semi-Independent Living Program (SILP), the Alternative Family Program (AF) and family support/respite services are now administered by BDDS through Supported Living. As of the end of 2003, 3,877 individuals benefited from Supported Living services and Medicaid waivers.

- SSI, a federal income support program available to persons who have disabilities and limited income and resources. The program provides up to $564 per month for eligible single people in 2004.

- Community and Home Options to Institutional Care for the Elderly and Disabled is a State funded program that supports the elderly and persons with disabilities. It can cover financial assistance for home modifications and various in-home supports (e.g., personal attendant care). The goal of the program is to enable the elderly and disabled to live as independently as possible. CHOICE dollars are all State funds, and CHOICE may fund up to $15,000 per person for home modifications. The original projections for the use of the CHOICE program were far exceeded. Between 1995 and 2000, the number directly served by CHOICE increased by nearly 30 percent each year. There is currently a waiting list for the services. A 2000 analysis of CHOICE beneficiaries found that more than 15 percent of individuals in the program were persons with disabilities.

- The Home and Community-Based Services (HCBS) program makes Medicaid waivers available for community support services in noninstitutional environments. They cannot be used to cover the cost of housing, although up to $10,000 can be used for environmental modifications. As of the end of 2003, 4,655 Hoosiers with developmental disabilities have been helped through the HCBS program.

- The U.S. Department of Housing and Urban Development's Section 811 program provides grants to nonprofit organizations to develop or rehabilitate rental housing. Nonprofit developers of such housing are granted interest free capital advances and rental assistance. The goal of the program is to increase the supply of rental housing with supportive services for people with disabilities, allowing them to live independently. The target population of the Section 811 program is very low-income individuals with physical or developmental disabilities who are between the ages of 18 and 62.

- CDBG, HOME, and tax credit funds can also be used to support the development of new housing, the construction of group homes, and provide rental assistance for people with developmental disabilities.

- The HomeChoice Program, offered by Fannie Mae and administered by housing finance authorities (including IHFA), offers conventional mortgage loan underwriting tailored to meet the needs of people with disabilities.

The Olmstead Supreme Court ruling. In June 1999 in the Olmstead V. L.C. case, the U.S. Supreme Court ruled that under the Americans with Disabilities Act, States are required to support individuals with disabilities in community settings rather than in institutions when it has been determined that community settings are appropriate and can be reasonably accommodated.

As a result, Indiana has formed the Governor's Commission on Home and Community-Based Services Housing Task Force. Its purpose is to coordinate existing resources and develop new housing solutions for persons at risk of being institutionalized. As of October 2002, the Housing Task Force will examine and report to the Commission on:

- The housing needs of people who are at risk of being institutionalized;

- The alternative housing solutions within Indiana, including a review of how other States have dealt with this issue and what is currently available in Indiana;

- The potential of replicating successful programs through creative funding mechanisms; and

- Develop potential recommendations in a report to be considered by the Commission that summarizes the focus of the Housing Task Force as it relates to current system barriers, current best practices, incentives for change, potential partnerships, recommendations for legislative and budget resources to support the system's change, evaluation criteria to measure effectiveness of change, and legislative and budget recommendations.

The Housing Task Force awarded mini-grants to got towards housing efforts. IHFA was awarded a $35,000 mini-grant June 2003 to support the re-establishment of the Indiana Low Income Housing Trust Fund Advisory Committee. The contact is currently being finalized. The Indiana Association for Community and Economic Development (IACED) was awarded a $31,429 mini-grant in August 2003 to implement a series of training and outreach activities. The activities increase the availability of community-based housing to persons with disabilities. Two specific markets to be targeted include: affordable housing suppliers and social service providers/supporters. The trainings will be held in May and June of 2004.

In June 2003, the Governor's Commission on Home and Community-Based Services released its report. The report includes a list of 28 new actions to serve as a blueprint for reform in Indiana. The actions are organized into four categories: rebalancing the long-term care system; the removal of barriers; community capacity; and children at-risk.

A few of the Actions include:

- Raise the monthly income eligibility standard for the Medicaid Aged and Disabled Waiver (and all other applicable waivers) to the federally-allowed limit of 300 percent (i.e., $1,656) of the Supplemental Security Income amount. This Action is further supported by a similar provision included in Senate Bill 493 (2003).

  - FSSA responded to this action by raising the monthly income standard for the Medicaid Aged and Disabled Waiver to the federally allowed 300 percent of the Supplemental Security Income amount (SSI).

- The Governor should appoint a Housing Task Force to focus on the housing issues of the elderly, disabled, and mentally ill populations. Membership should include: representatives of the housing industry, especially builder and contractors who have expertise and experience in new construction; consumers; advocacy groups; legislators; representatives of public/private funding sources; and service providers.

- The Governor should work with the Indiana General Assembly to establish a real estate transaction fee to be assessed in the transfer of all commercial, farm, and residential real estate. The proposed fee per transaction would be dedicated to the Indiana Low Income Housing Trust Fund.

- A Business Leadership Network should be developed in Indiana to establish and further strengthen the link between business and employment at the local and state levels. Business Leadership Networks assist employers by exploring methods to more effectively recruit, market, and hire the talents of job applicants with disabilities. Business Leadership Networks have been developed across the country as part of an initiative started by the Office of Disability Employment Policy (ODEP) and supported by the U.S. Chamber of Commerce.

The report discusses that affordable and accessible housing is in very short supply. In fact, data indicates there are 3,700 households receiving housing assistance through Indiana's Housing Choice Voucher Program (Section 8), two-thirds of which have elderly or disabled members. This compares to a very high demand for this assistance with over 7,000 households on the pre-application list waiting for assistance. It is for this reason that the issue of housing warrants special attention and cannot be fully resolved with the identification of a few critical actions.[6]

Employment program for people with disabilities. Nationally there has been an emphasis on integrated supported employment from traditional segregated day activity programs for persons who are disabled. In 1985, the U.S. Department of Education issued a request for proposals with the intent of fostering systematic statewide efforts to provide paid, integrated community employment opportunities for people with significant disabilities who require ongoing support to participate successfully in the competitive labor force. By 1998, all but two states had received one or more supported employment systems change grants from the Department of Education.[7]

According to the 2000 U.S. Census, 14.5 percent of the population aged 16 to 64 years who were employed had a disability. This is slightly lower than the national average of 14.8 percent of the employed population aged 16 to 64 years with a disability. The National Organization on Disability "State of the Union 2002 for Americans with Disabilities" reported employment was the largest gap area, with 68 percent unemployment, despite the fact that two out of three individuals with disabilities wanted to work. According to a Harris Poll, 32 percent of Americans with disabilities ages 18 to 64 were working versus 81 percent of non-disabled adults.

According to a study done in 1998, participation in supported employment programs had grown from 9,800 in 1986 to over 140,000 in 1995. There have been documented employment successes achieved by individuals with the most challenging support needs and individuals with various disabilities. Participants in integrated employment with adequate support to get and keep a job have obtained decent jobs with fair wages and the individualized accommodations and adaptations have provided greater access and independence for many.

A 2002 study examined changes in wages, work hours, benefits, and integration outcomes by former segregated workers to integrated work environments. The findings include:

- Employees earned over twice the wages, on average, in community jobs than they had earned in the sheltered facility;
- Mean hourly wage was $5.75 for supported employment and $2.30 for sheltered work;
- Only 38 percent received benefits when they were in the sheltered facility, whereas 50 percent received benefits when they obtained integrated employment; and
- Most individuals (73 percent) had no contact with people without disabilities in their immediate environment while in sheltered facilities, while 94 percent of all supported employees had nondisabled coworkers in their immediate environment.

[6] Governor's Commission on Home and Community-Based Services, June 30, 2003 Report.

[7] Rogan, Dr. Patricia, *A Rational for Integrated Job Training & Employment for People with Disabilities.* December 2003.

There is currently an outstanding need to get current policies aligned with the shift in funding to integrated employment. There is also minimal expertise within the social services about the business community and few contacts within the business community. Education about the process and benefits of the integrated employment system for the business community is also important to improve and expand the program.

The following is a description of two organizations in Indiana that that promote individualized and integrated employment.

- **Gateway Services.** Gateway Services has been in existence for 25 years providing facility based sheltered workshop and day activity services for people with significant disabilities. Over a 10 year period, Gateway stopped running a sheltered workshop and assisted approximately 150 people to secure employment in the community. The organization learned that when people become apart of their community and become taxpaying citizens, their lives are enhanced.

- **Options for Better Living.** Options, based in Bloomington, is an organization that has been shifting its focus away from providing group home services to integrated supported employment and supported living services for persons who experience disabilities. People supported by Options have gained skills, friends, increased independence, and richer lives as a result of their membership in the community.

The Indiana Conversion Task Force (CTF) is a group comprised of representatives of state agencies, advocacy organizations, Independent Living Centers, Community Rehabilitation Programs, and the Indiana Institute on Disability and Community. The purpose of the CTF is to promote a shift in philosophy, policies, funding, and services from facility-based community based employment and supports for adults with disabilities in Indiana.

The group has been meeting since 1997 in an advisory capacity. All of the goals listed in Exhibit V-12 reflect the priority of integrated community-based services and a reduction of congregate, segregated services. These priorities mesh with federal legislation (e.g., ADA, Workforce Investment Act/Rehabilitation Act) and State plans (e.g., FSSA work plan and 317 Task Force plan).

Exhibit V-12.
Indiana Conversion Task Force Priorities for FY2002-2003

Fiscal Recommendations

Fiscal Incentives:

- Provide fiscal incentives for community-based day services. Rates for supported employment and related community supports must be higher than for facility-based services.
- Eliminate new Title 20 funding to sheltered facilities.

Individualized Budgets:

- Tie funding to individuals to purchase integrated, community-based services and supports (including MRO, Title XX, Ticket-to-Work, group home day services money, Medicaid Waivers).

Philosophy/Practice Recommendations

Shift People from Facilities to Community:

- The number of people and the hours they are served in integrated employment and community activities will exceed the number and hours people spend in facility-based day services by the year 2006.

State Leadership:

- FSSA will promote a clear and consistent message prioritizing community and integrated employment services across all divisions.

Provider Standards:

- Provider Standards should make it very difficult for someone to enter and stay in facility-based services. Providers need to utilize person-centered planning and emphasize integrated services.

Medicaid Waivers & SE:

- Significantly increase use of Medicaid Waivers for supported employment with adequate funding.

Training & Technical Assistance:

- Provide training to agencies, case managers, etc. re: integrated employment and community services.

Source: Indiana Conversion Task Force Priorities, FY2002-2003.

Persons with HIV/AIDS

Total population. Among the 50 States and the District of Columbia, Indiana ranked 27th in HIV and AIDS prevalence, with an annual case rate of eight per 100,000 people in 2002. According to the Indiana State Department of Health, 208 new HIV and AIDS cases were reported in Indiana between October and December 2003.

In February 2003, AIDS Housing of Washington completed the *Indiana HIV/AIDS Housing Plan* for the Indiana Housing Finance Authority, the City of Indianapolis and The Damien Center. The study found that as of June 2002, there were a reported 3,368 people living with AIDS and another 3,668 people living with HIV who have not been diagnosed with AIDS Statewide. Since data have been collected on the epidemic, 11,994 people have been diagnosed with HIV and/or AIDS in Indiana.

The State has divided its service areas for people with HIV/AIDS into twelve geographic regions. As of December 2003, Region 1 (Gary) and Region 7 (Indianapolis) accounted for nearly 60 percent of people with living with HIV in Indiana. However, at least 240 cumulative cases of HIV and at least 124 people living with HIV and AIDS have been reported in each region since reporting began in 1986. Exhibit V-13 presents the number of people living with HIV by region as of December 2003.

Exhibit V-13.
Number of people living with HIV by Region, December 2003

Source:
Indiana HIV/STD Quarterly Report, December 2003.

Region	Counties	People living with HIV
1	Lake, LaPorte, Porter	1,047
2	Elkhart, Fulton, Marshall, Pulaski, St. Joseph, Starke	484
3	Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, Whitley	435
4	Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, White	144
5	Blackford, Delaware, Grant, Jay, Randolph	176
6	Cass, Hamilton, Hancock, Howard, Madison, Miami, Tipton	424
7	Boone, Hendricks, Johnson, Marion, Morgan, Shelby	3,208
8	Clay, Parke, Putnam, Sullivan, Vermillion, Vigo	283
9	Dearborn, Decatur, Fayette, Franklin, Henry, Ohio, Ripley, Rush, Union, Wayne	120
10	Bartholomew, Brown, Greene, Lawrence, Monroe, Owen	243
11	Clark, Crawford, Floyd, Harrison, Jackson, Jefferson, Jennings, Orange, Scott, Switzerland, Washington	268
12	Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick	334
	Total	**7,166**

The Indiana State Department of Health reported of the cumulative cases of HIV and AIDS reported through December 31, 2003, 85 percent of persons with HIV/AIDS in Indiana are male, while approximately 49 percent of the population as a whole is male. In addition to males, African Americans and Hispanics are also disproportionately more likely to have the disease. Although white residents of Indiana account for 89 percent of the State's population, only 65 percent of the State's residents with HIV and AIDS are white. Meanwhile, African Americans comprise only 9 percent of the State's population, yet account for almost one-third of residents living with HIV and AIDS.

According to the *Indiana HIV/AIDS Housing Plan*, approximately 800, or 12 percent, of the 6,408 persons with HIV/AIDS in Indiana reside in non-MSA counties; although 60 percent of the population resides in non-MSA counties.

Outstanding need. Providers of services to people with HIV/AIDS estimate that between 30 and 50 percent of the number of people with HIV/AIDS need housing. This suggests housing needs for between 2,150 and 3,583 people living with HIV/AIDS in the State. Part of the *Indiana HIV/AIDS Housing Plan* study included focus groups of people living with HIV/AIDS in Indiana. These focus groups cited housing affordability as the primary housing challenge. Other concerns noted by the focus group participants included the quality of housing that is affordable to them, the desire to live independently and confidentiality when accessing services. AIDS Housing of Washington also conducted a survey of 418 people living with HIV/AIDS throughout the State. Survey findings included:

- Survey respondents had very low-incomes;
- Many survey respondents received some housing assistance, but most still pay a large portion of their income for housing;
- Consistent with the preferences expressed, the majority of respondents lived alone and rented their homes;
- Behavioral health issues, such as mental health and substance abuse, affected a small but considerable percentage of people living with HIV/AIDS; and
- Many respondents had experienced homelessness.

The survey also collected income and cost burden data of respondents. Exhibit V-14 on the next page summarizes median income, median housing costs and the cost burden of respondents by region.

Exhibit V-14.
Income and Cost Burden of Survey Respondents, 2001-2002

Source:
AIDS Housing of Washington, *Indiana HIV/AIDS Housing Plan,* February 2003.

Region	Median Income	Median Housing Costs	Cost Burden
Region 1 (Gary)	$665	$415	52%
Region 2 (South Bend)	$597	$371	54%
Region 3 (Fort Wayne)	$601	$398	52%
Region 4 (Lafayette)	$653	$309	52%
Region 5 (Muncie)	$595	$500	53%
Region 6 (Anderson)	$787	$467	38%
Region 7 (Indianapolis)	$591	$413	44%
Region 8 (Terre Haute)	$551	$513	78%
Region 9 (Richmond)	$635	$314	37%
Region 10 (Bloomington)	$764	$453	50%
Region 11 (Jeffersonville)	$617	$293	45%
Region 12 (Evansville)	$598	$350	43%

The *Indiana HIV/AIDS Housing Plan* reported there were 143 existing housing units for persons with HIV/AIDS in 2001 and 190 persons receiving long-term rental assistance with HOPWA dollars. Assuming the total number of persons with HIV/AIDS with a need for housing assistance to be 2,111 (30 percent of the HIV/AIDS population), the State faces an outstanding need of over 1,778 housing units for persons with HIV and AIDS. Surveys indicate that among persons living with HIV/AIDS, most desire to live in single family homes rather than apartments. The most desired types of housing subsidies are mortgage or rental assistance, followed by subsidized housing and units with some supportive services.

Barriers to housing. In addition to living with their illness and inadequate housing situations, persons with HIV and AIDS in need of housing face a number of barriers, including discrimination. The co-incidence of other special needs problems with HIV/AIDS can make some individuals even more difficult to house. For example, 10 percent of *Indiana HIV/AIDS Housing Plan* survey respondents indicated alcohol or drug use. Approximately 12 percent of HIV/AIDS survey respondents indicated mental health or psychiatric disability. Because of the frequent concurrence of substance abuse and mental illness with HIV/AIDS and the need for health care and other supportive services, many of those with HIV/AIDS can be very difficult to serve.

Additionally, the study's Steering Committee, consumers, providers of HIV/AIDS services and survey respondents identified the following barriers to achieving and maintaining housing stability:

- Poor credit;
- Recent criminal history;
- Poor rental history, including prior eviction and money owed to property managers; and
- Active substance abuse.

Housing. The 11 regions of the State that are covered by the State HOPWA funds (Region 7, which includes Indianapolis, is funded separately through the City of Indianapolis) provide a total of 143 housing units dedicated to persons living with HIV/AIDS as of 2001. In addition to the units set aside for persons with HIV/AIDS Statewide, each of the 11 geographic service areas are available to assist persons with HIV/AIDS through short-term rental assistance, long-term rental assistance, housing referrals and other supportive services. From June 2003 to February 2004, there were 90 tenant-based rental assistance vouchers. Exhibit V-15 on the following page shows, by geographic service area, the number of persons with HIV/AIDS who were supported through either short-term or long-term rental assistance between July 2003 and February 2004.

Exhibit V-13.
Short- and Long-Term Rental Assistance for Persons with HIV/AIDS by Geographic Service Region, July 1, 2003 to February 2004

HIV Care Coordination Region (City)	Region Name	Tenant-Based Rental Assistance	Short-Term Rent, Mortgage and/or Utility Assistance
Region 1 (Gary)	Greater Hammond Community Services, Inc.	34	7
Region 2 (South Bend)	AIDS Ministries/AIDS Assist of North Indiana	13	21
Region 3 (Fort Wayne)	AIDS Task Force of Northeast Indiana	7	52
Region 4 (Lafayette)	Area IV Agency on Aging and Community Action Programs	7	11
Region 5 (Muncie)	Open Door Community Services	1	16
Region 6 (Elwood)	The Center for Mental Health	4	10
Region 8 (Terre Haute)	Area VII Agency on Aging and the Disabled/West Central Indiana Economic Development District	11	12
Region 9 (Richmond)	AIDS Task Force of Southeast Central Indiana	6	22
Region 10 (Bloomington)	Positive-Link/Bloomington Hospital	9	26
Region 11 (Jeffersonville)	Clark County Health Department (Hoosier Hills AIDS Coalition)	2	3
Region 12 (Evansville)	AIDS Resource Group and Evansville Housing Authority	4	23
	Total	**98**	**203**

Note: Region 7 (Indianapolis) is funded separately through the City of Indianapolis.
Source: IHFA, February 19, 2004.

Resources. The primary source of funding for HIV/AIDS housing is the Housing Opportunities for People with AIDS (HOPWA) program. From July 2003 to June 2004, IHFA allocated $768,129 in HOPWA funds to 12 agencies in 11 of the State's 12 regions (Region 7, which includes Indianapolis, is funded separately through the City of Indianapolis). These funds are available for use as rental subsidies, as well as emergency services, such as utility assistance and emergency medicine. Awards of HOPWA funds are made on an annual basis. Exhibit V-16 displays the HOPWA awards made for July 2003 through June 2004.

Exhibit V-16.
HOPWA Awards by Category of Service, July 2003 to June 2004

Category of Service	Award Amount	Percent of Total
Tenant-based Rental Assistance	$385,624	50%
Short-term Rental, Mortgage and Utility Assistance	142,421	19%
Support Services	$128,738	17%
Housing Information	$27,900	4%
Program Delivery (Tenant-based Rental and Short-term Assistance)	$33,176	4%
Administration	$43,042	6%
Resource Identification	$500	0%
Operating Costs	$6,728	1%
Total	**$768,129**	**100%**

Source: IHFA, February 2004.

Exhibit V-17 presents the allocation of funds by counties served, projects sponsors, allocation amount and percent of total HOPWA funding from July 2003 to June 2004 for the State of Indiana HOPWA program, outside of the Indianapolis MSA.

Exhibit V-17.
HOPWA Program Awards by Region and Activity, July 2003 to June 2004

Region	Counties Served	Project Sponsor	Award Amount	Percent of Total
1	Lake, LaPorte, Porter	Greater Hammond Community Services, Inc.	$192,000	25.0%
1	Lake, LaPorte, Porter	Brothers Uplifting Brothers, Inc.	$30,000	3.9%
2	Elkhart, Fulton, Marshall, Pulaski, St. Joseph, Starke	AIDS Ministries/AIDS Assist of North Indiana	$104,159	13.6%
3	Adams, Allen, Dekalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, Whitley	AIDS Taskforce of Northeast Indiana	$101,062	13.2%
4	Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, White	Area IV Agency on Aging and Community Action Programs	$37,019	4.8%
5	Blackford, Delaware, Grant, Jay, Randolph	Open Door Community Services	$42,508	5.5%
6	Cass, Howard, Miami, Tipton	The Center for Mental Health	$27,869	3.6%
8	Clay, Parke, Putnam, Sullivan, Vermillion, Vigo	Area VII Agency on Aging and the Disabled/West Central Indiana Economic Development District	$60,384	7.9%
9	Decatur, Fayette, Franklin, Henry, Ripley, Rush, Union, Wayne	AIDS Task Force of Southeast Central Indiana (Richmond)	$27,447	3.6%
10	Bartholomew, Brown, Greene, Lawrence, Monroe, Owen	Positive-Link/Bloomington Hospital	$55,457	7.2%
11	Crawford, Jackson, Jefferson, Jennings, Orange, Switzerland, Washington	Hoosier Hills AIDS Coalition/Clark County Health Department	$13,372	1.7%
12	Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick	AIDS Resource Group of Evansville, Inc.	$76,852	10.0%
		Total	**$768,129**	**100%**

Note: Region 7 (Indianapolis) is funded separately through the City of Indianapolis.
Source: IHFA, February 19, 2004.

In addition to HOPWA funds, the Indiana State Department of Health administers four additional programs for people living with HIV/AIDS, including:

- *HIV/AIDS Services Program*: This program is State-funded. This program pays for care coordination at 18 sites throughout the State. Funding for grant year 2004-2005 is $2,452,500.

- *Special Population Support Program*: This program is State-funded administered by the FSSA. This program provides substance abuse and mental health support services throughout the State. Funding for grant year 2004-2005 is $900,000.

- *HIV/AIDS Education Program*: This program is State-funded. This program pays for prevention and education programs. Funds are sub-granted to community action programs throughout the State. Funding for grant year 2004-2005 is $674,802.

- *Social Services Block Grant*: This program is federally funded. This program also provides care coordination at two of the 18 sites throughout the State. Funding for grant year 2004-2005 is $561,206.

- *Ryan White CARE Act – HIV Medical Services Program*. This program is federally funded and awarded to the State. Title II of the Ryan White CARE Act in Indiana primarily is used to purchase HIV medications, services and insurance coverage for eligible HIV positive state residents. The program is known simply as the HIV Medical Services Program. The expected award for 2004 is $10,080,837. Eligible applicants must be living below 300 percent of the federal poverty level and must not have access to public or private health coverage. The program is administered centrally by the State Department of Health and a contracted third-party claims payer. Participants are required to enroll in the State's case management program (Care Coordination) as well. A portion of the award covers normal administration costs, quality management projects, advisory council expenses, and special set-aside projects (i.e., Emerging Communities and Minority AIDS Initiative).

Persons with Physical Disabilities

Total population. Estimates of the total population in Indiana with physical disabilities vary according to the definition of disability. The 2000 Census definition of disability encompasses a broad range of categories, including physical, sensory and mental disability. The Census classifies individuals as having a disability if any of the following three conditions are true:

- They were five years old and over and, on the 2000 Census survey, had a response of "yes" to a sensory, physical, mental or self-care disability;

- They were 16 years old and over and had a response of "yes" to going outside the home disability; or

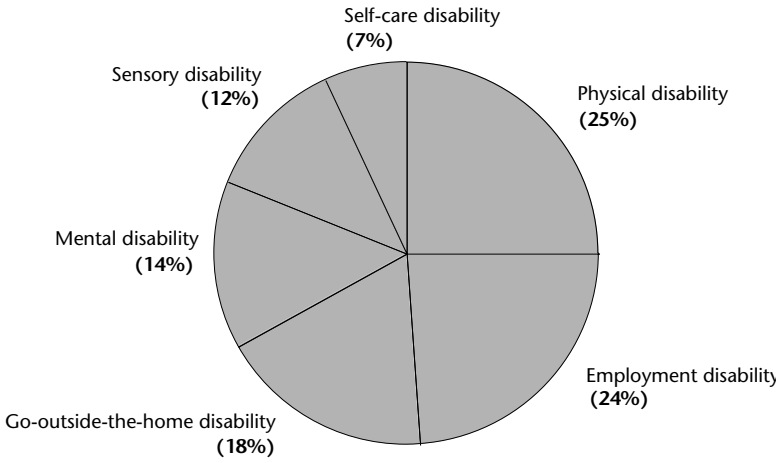
- They were 16 to 64 years old and had a response of "yes" to employment disability.

The Census definition of people with disabilities includes individuals with both long-lasting conditions, such as blindness, and individuals that have a physical, mental or emotional condition lasting 6 months or more that makes it difficult to perform certain activities. In 2000, 1,054,757 Hoosiers over the age of five indicated disability status. Nearly 321,000 lived in entitlement cities, indicating that approximately 734,000 persons with disability status resided in rural areas.

The 2000 Census also reports total disabilities by type of disability for the population five years and older. Exhibit V-18 below displays the distribution of *types of disabilities* in Indiana in 2000.

Exhibit V-18.
Types of Disabilities, 2000

Source:
U.S. Bureau of the Census, 2000.



Of all disabilities, physical disability is the most prevalent, comprising one-quarter of all types of disabilities. According to the U.S. Census, seniors aged 65 and over compose 45 percent of persons with a physical disability, and 28 percent of all elderly had some form of physical disability.

Outstanding need. The Governor's Planning Council for People with Disabilities (GPCPD) recently conducted a consumer survey of nearly 1,400 Indiana residents with disabilities and held various focus groups with representatives from nonprofit organizations and advocacy groups as part of their *Five Year State Plan for People with Disabilities* (2001–2005). Through their research, they identified the following "key issues" for Indiana residents with disabilities:

- **Home and community-based services.** Indiana residents with disabilities believe that services delivered to their homes and places of work provide the greatest benefit, and they desire more options and greater investment in the implementation of such services.

- **Waiting lists.** Currently, thousands Hoosiers with disabilities are waiting for home and community-based care services. According to the GPCPD report, "The issue is not just that waiting is hard, but many people's conditions deteriorate while they are waiting for services."

- **Full utilization of Vocational Rehabilitation Services funds.** Indiana residents with physical disabilities who participated in the survey indicated that they believe the available Vocational Rehabilitation Services programs are currently under-utilized.

A recent study, *Priced Out in 2002*, compared average monthly SSI payments with rental housing costs at the national level and for each State. The study concluded that persons with disabilities receiving SSI income support lost "buying power" in the nationwide rental housing market over the past two years. The study also found that in Indiana, the monthly SSI benefit of $545 represents only 16.6 percent of Statewide one-person median income. A person with disabilities receiving SSI income support in Indiana would have to pay 83.5 percent of this monthly benefit to be able to rent a modestly priced one-bedroom unit. (In 2004, the SSI benefit was raised to $564 per individual — an increase of $19).

Housing direction established by the Governor's Council. The latest Five Year State Plan for People with Disabilities identifies self-determination, employment, and community inclusion as three primary objectives to be addressed for persons with disabilities. Research presented in the plan indicates that persons with disabilities want to live in a community with privacy, safety, and without fear of being raped, abused or belittled. They need supportive services to make this possible. Some require the support of assisted living, but not regimentation. Those who are married expect to be able to live together. Group homes and Independent Living Centers are helping people become more self-sufficient, but they need well-trained, permanent staff who can teach life skills.

Issues addressed through the community inclusion objective involve the reliance on sheltered, segregated services, a dependent living bias and a lack of commitment to community integration (as evidenced by the small number of community-based support systems, the large number of people in nursing homes and the lack of accessible, affordable housing).

The GPCPD has identified the following four objectives aimed at addressing the community inclusion initiative:

- Increase the number of children with disabilities, including those with emotional disabilities, in inclusive educational settings;
- Increase the number and quality of community living supports that enable people with disabilities and families to participate in inclusive community activities of their choice;
- Expand the number of people with disabilities who have accessible, affordable housing; and
- Expand the availability of accessible, affordable public and private transportation throughout the State, especially in rural areas.

Resources. GPCPD plans to address the objective of expanding the number of persons with disabilities who have accessible, affordable housing through the implementation of the following strategies:

- Promote interagency coordination around quality housing;
- Build supports that enable people to live in their own houses;
- Educate about and advocate for the benefits of universal design with housing designers, developers and builders as well as the general public; and
- Promote awareness in the housing industry that persons with disabilities are viable customers.

In addition, the Five Year Plan identifies a vision for the future of community living for persons with disabilities. This vision includes the establishment of affordable and accessible, individualized and dispersed housing for people with disabilities of all ages throughout the community, and the direction of funding away from services/buildings that congregate people with disabilities. This vision includes the provision of individualized supports to meet people's needs in their own homes (ownership or rental).

Many of the programs (including CDBG and HOME) available to persons with developmental disabilities are also available to persons with physical disabilities. Individuals with physical disabilities also have access to the following financial and supportive service programs to help meet their housing and support needs:

- Supplemental Security Income (SSI) is a federal income support program that is available to people who have disabilities and limited income and resources. Effective January 2004, the SSI basic benefit payment is $564 a month for an eligible individual and $846 a month for an eligible couple. The State of Indiana does not add any money to the basic benefit.

- Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) is a State funded program that supports the elderly and people with disabilities. It can cover financial assistance for home modifications and various in-home supports (e.g., personal attendant care). In 1998 (the date of the last available data), approximately 1,800 Indiana residents with physical disabilities received CHOICE funds (18 percent of the total number of CHOICE fund recipients). In SFY2001 there were a total of 12,537 persons served by CHOICE and 2,666 of those residents (21 percent) were under 60 years with physical disabilities. The number of residents over 60 years with physical disabilities was not provided.

- Medicaid services are available meet the needs of individuals living in the community, large and small congregate facilities or who are receiving care in a hospital. Medicaid waivers make Medicaid funding available for home and community based services that have the support services they need to live in their own homes. Medicaid waiver funding cannot be used to cover the cost of housing, although up to $10,000 can be used for environmental modifications. In 1999, 71,682 Indiana residents with disabilities received over $100 million in Medicaid funds. Effective July 1, 2003 Medicaid participants receiving institutional care who are clients of the Autism and Developmental Disability waiver programs will have $1,000 available to them for out-of-pocket expenses when transitioning from institutions to community settings. The allowance will pay for the client's initial security deposit on an apartment, essential furnishings, pest eradication and set up fees for utilities and telephones.

Persons with Mental Illness or Substance Abuse Issues

Total population. It is appropriate to consider persons with mental illness and those with substance abuse issues together because Indiana uses one system to serve both of these populations.[8] The most recent estimates developed by the State's Division of Mental Health place the population of persons with mental illnesses at approximately 236,831. A recent actuarial study estimates the target population for State services (e.g., the poorest and least able to secure services) at 68,311.

It is estimated that 0.43 percent of Indiana's population are substance abuse clients in specialty treatment units on any given day. Given the 2003 population of 6,195,643 people, this would result in a total of 26,641 substance abuse clients Statewide.

If the prevalence of mental illness and substance abuse were the same in nonentitlement areas as the State as a whole, they would be home to approximately 145,000 people with mental illness and 15,776 substance abuse clients.

Exhibit V-19 below displays the number of people served by the Indiana Division of Mental Health and Addiction (DMHA) from July 1, 2002 to June 30, 2003. The clients identified are all adults (18 years and older) who received services through community mental health centers and/or managed providers funded by the Indiana DMHA and Addiction Hoosier Assurance Plan (HAP). Clients included met specific income and diagnostic criteria. The number of individuals displayed below represents an unduplicated count of persons. Individuals are entered only once into the DHMA database per fiscal year, and may only be categorized in one "agreement type," i.e. seriously mentally ill, chronically addicted/substance abuse, per fiscal year.

Exhibit V-19.
Number of People Served by the Indiana DMHA,
July 2002 to June 2003

Population	Homeless	Not Homeless	Not Applicable	Rural	Urban	Total
Seriously Mentally Ill	1,427	43,172	3,419	11,999	36,019	48,018
Chronically Addiction	1,804	18,211	4,280	5,380	18,915	24,295
Compulsive Gambling Addiction	13	116	24	22	131	153
Total Population	**3,244**	**61,499**	**7,723**	**17,401**	**55,065**	**72,466**

Source: Indiana Division of Mental Health and Addiction, e-mail from Yuri Kirilusha, 2/26/2004.

[8] Persons with mental illness are also often referred to as "persons with psychiatric disabilities." This report uses the term "persons with mental illness," which is currently used by HUD.

Outstanding need. One method of determining outstanding need among persons with mental illness in the State is to compare the current availability of supportive services slots with the current need. As of 2000, there were 1,335 supportive services slots for individuals in Indiana, 291 less than the estimated need of 1,626. For families in need of supportive services, a demand of 900 slots exists, exceeding the supply of 810 by 90. Persons with serious mental illness face an even bigger gap between need and availability of services. While an estimated 616 supportive services slots exist for individuals and 78 for families, approximately 955 slots are needed for individuals and 339 for families – creating an outstanding need of 616 for individuals and 282 for families.

It is estimated that there are 97.5 beds available for substance abuse treatment per 100,000 people in the United States. Given this estimate, Indiana would have 5,662 total beds targeted to persons with substance abuse.

FSSA served 38,199 Hoosiers suffering from mental illness in 2001. Among this group, 70 percent were in independent living situations, i.e., living in their own homes or apartments or in independent living situations with parents or relatives. An additional 14 percent were living with parents, guardians or other caregivers, 3 percent were homeless and 7 percent were living in group homes, institutions or other supervised, dependent settings. Approximately 73 percent of clients served by FSSA in 2001 were from urban areas in the State; 27 percent were from rural areas; 40 percent of FSSA clients with mental illnesses were not in the labor force in 2001; 31 percent were unemployed; 4 percent worked full time; and 11 percent worked less than full time.

The FSSA completed their third annual State Operated Facilities (SOF) Community Readiness Report. The study, also known as the State Hospital Client Readiness Assessment, is part of the DHMA mandate to develop plans for the State operated psychiatric facilities. This mandate, which comes from both State and federal resources, requires that the plan be based on individual client assessments relative to the clients' readiness for community-based care. Community Mental Health Centers (CMHC) and State Hospitals evaluated 650 consumers in State operated facilities in August 2002. Consumers with a serious mental illness (SMI) constituted 510 (or 78 percent) of those evaluated. Consumers were evaluated based on the expected date at which they would be ready to leave the hospital and the availability of the kind of setting that they would need. Exhibit V-20 displays the results of the evaluation.

Exhibit V-20.
Community Setting Availability, 2002

All Populations (SMI, MICA and SED)	Setting Exists	Setting Being Developed	Setting Full with Waiting List	Setting Exists Out of Home Area	Setting Does Not Exist	Total
Ready for discharge	**8%**	1.2%	3%	1%	**1%**	14%
1 month to 6 months	**20%**	3%	6%	1%	**0.5%**	31%
6 to 12 months	**12%**	2%	4%	0%	**1%**	18%
1 to 2 years	**8%**	0.5%	2%	1%	**2%**	13%
2 years or more	**5%**	0.2%	0%	1%	**6%**	12%
May never be ready	**4%**	0%	0.5%	1.1%	**6%**	12%
Total	**56%**	**7%**	**15%**	**5%**	**16%**	**100%**

Note: SMI = Serious Mental Illness, MICA = Chemically Addicted, and SED = Serious Emotional Disturbance.
Source: State Operated Facilities Community Readiness Report. SFY 2003.

As shown in the table above, 14 percent of the total 650 consumers were determined to be ready for discharge at the time of the assessment. This 14 percent was evenly distributed throughout the State. Overall, 202 or 31 percent of seriously mentally ill (SMI), mentally ill and chemically addicted (MICA) and serious emotional disturbance (SED, includes only children and adolescents) populations were evaluated to be placement ready within one to six months.

The study found that 56 percent of all consumers assessed had an existing setting available, or would have a setting available at the time of discharge. The majority of the balance of consumers, regardless of their discharge status, were categorized under facilities that were full with a waiting list (15 percent) and/or did not have facilities that would suit their needs (16 percent).

In terms of placement needs, supervised group living (SGL) settings were determined most appropriate for 220, or 43 percent, of the SMI population. Ten percent were determined to need placement within a medical or nursing facility for extended care. A total of 58 MICA consumers were assessed; 26 percent were evaluated to need specialized residential treatment services for substance abusers, and 48 percent were divided equally indicating discharge to their family/personal home or a need for supervised group living. For SED consumers, it was anticipated that 65 percent of these children and adolescents would need to return to a family setting.

Provision of housing to persons who are mentally ill or abuse substances in rural areas is difficult due to two factors. First, rental properties, particularly apartments, are less common outside of large cities. Additionally, HUD's scoring system for Section 811 grants uses minority participation as a significant factor in evaluations. Given the small number of minorities in the State's nonentitlement areas, this requirement puts applications from such areas at a disadvantage from the outset. Due to these factors, and the fact that all of the State's Mental Health Services for Homeless Persons with Mental Illness (PATH) programs are located in large cities, it seems likely that there is an outstanding need for housing for the mentally ill and for individuals with substance abuse problems in nonentitlement areas in Indiana.

Resources. Through the Hoosier Assurance Plan, the State's Division of Mental Health contracts with managed care providers who provide services to individuals requiring mental illness or substance abuse treatment and who have annual incomes falling beneath 200 percent of federal poverty guidelines. The Division has statutory authority for 44 managed care providers Statewide. Each provider is reimbursed on a per consumer basis from the State. Since Indiana is consciously trying to downsize its State hospitals and de-institutionalize its mental health system, Community Mental Health Centers (CMHC) are also allowed to "cash in" allocated State hospital beds for additional resources. CMHCs provide the following mandated services: inpatient services, partial hospitalization/psychosocial rehabilitation, residential services, outpatient services, consultation, education and community support. Priority populations are adults with chronic mental illness and children and adolescents who are seriously emotionally disturbed. In 2001, the Hoosier Assurance Plan supported more than 84,000 persons with mental illness.

In 2001, the Indiana division of the National Alliance for the Mentally Ill (NAMI) conducted a residential survey of CMHCs throughout the State. Approximately 30 CMHCs responded to the survey and reported nearly 1,900 beds or units available for people with mental illness. The survey identified units that were owned by CMHCs, in addition to subsidized units or residences for clients they served. Types of units included group homes, HUD apartment complexes, cluster homes, assisted living, emergency housing and home-based services, among other types of living arrangements. Exhibit V-21 on the following page displays the CMHCs who completed the survey and the number of beds/units they have available.

Exhibit V-21.
2001 NAMI Indiana Survey of Community Health Mental Centers

Resource	Area Served	Units/Beds
The Center for Mental Health	Anderson	70
Center for Behavioral Health	Bloomington/South Central Indiana	N/A
BehaviorCorp	Marion, Boon, Hamilton Counties	50
Quinco Behavioral Health Systems	Columbus, North Vernon, Seymour	44
Cummins Mental Health Center, Inc.	Greencastle, Brownsburg	13
Tri-City Community Mental Health Center	Hammond, Munster, Whiting, East Chicago	40
Oaklawn Psychiatric Center	Elkhart	33
Southwestern Indiana Mental Health Center, Inc.	Evansville	40
Park Center	Fort Wayne	140
Edgewater Systems Residential Services	Gary	72
Adult & Child Mental Health Center	Indianapolis	N/A
Gallahue Mental Health Center	Indianapolis	57
Midtown Community Mental Health Center	Indianapolis - Center, Wayne Townships	96
Southern Hills Counseling Center, Inc.	Jasper	10
LifeSpring Mental Health Services	Jeffersonville	377
Northeastern Center, Inc.	Kendallville	20
Howard Community Hospital	Kokomo	40
Community Mental Health Center	Lawrenceburg	N/A
Four County Counseling Center	Logansport, Cass County	41
Grant-Blackford Mental Health, Inc.	Marion, Grant County	130
Southlake Center for Mental Health	Merrillville, Schereville, Lake County	85
Swanson Center	LaPorte County, Michigan City	28
Comprehensive Mental Health Services, Inc.	Muncie	91
Dunn Center	Richmond	98
Madison Center and Hospital	South Bend	83
Hamilton Center, Inc.	Terre Haute and Marion	55
Porter-Starke Services, Inc.	Valparaiso	15
Samaritan Center	Vicennes	55
Bowen Center	Warsaw	79
Wabash Valley Hospital	West Lafayette	N/A
Entitlement areas		**887**
Nonentitlement areas		**975**
Total		**1,862**

Note: It is likely that this estimate is slightly lower or higher as the survey was conducted in 2001.
Source: Indiana National Alliance for the Mentally Ill, 2001.

The Division of Mental Health supports eight Mental Health Services for Homeless Persons with Mental Illness (PATH) teams and four CMHCs with Shelter Plus Care programs. These provide housing, job training, case management, medical services and referrals. In addition, most CMHCs also serve persons experiencing homelessness through referrals from other agencies. It should be noted that the PATH teams are all located in Indiana's six largest cities, meaning that few of these housing services are available in nonentitlement areas. A PATH-like team has recently been funded at the Center for Mental Health in Anderson using Mental Health Block Grant funds.

In addition to State-provided services, Indiana's statutes require employers who provide mental health coverage to provide it in full parity with physical health coverage. Furthermore, the State's Children's Health Insurance Program provides full parity for mental illness.

As noted earlier, the State's Continuum of Care recently addressed the needs of people with mental illness who are also homeless. In regard to this population, the Homeless Task Force's 2003-2004 goals aim to:

- Improve working relationships between mental health centers and homeless providers to ensure better access to services by mentally ill homeless persons (ongoing);
- Survey mental health centers by December 2002 (completed);
- Develop model service agreements (ongoing);
- Establish service agreements between at least 75 percent of the mental health centers with homeless service providers by May 2003 (ongoing - DMHA reports that many of the mental health centers have good verbal agreements in place with homeless service providers. DMHA is reviewing how those agreements are working out.); and
- Highlight mental health centers that have established strong relationships with homeless service providers at the March 2003 training sessions (ongoing – Did not do in 2003. Task Force will include with 2004 CoC trainings).

Migrant Agricultural Workers

Total population. By definition, the number of migrant agricultural workers in Indiana fluctuates and, consequently, is difficult to measure. The most recent count identified a total of 3,552 migrant workers employed by 130 employers throughout the State. However, this count does not include seasonal workers, which are very difficult to measure due to their transient nature. Thus, the total of migrant and seasonal workers is much higher than this identified count. Due to the difficulty of locating workers, service providers estimate the State's annual population of migrant workers at about 8,000. Records from the Department of Labor's Transition Resources Program indicate that over 85 percent of migrant farm workers that receive services are Latino and nearly 50 percent have limited English-speaking abilities.

Outstanding need. There are no recent studies of the needs of migrant farm workers in Indiana. The most comprehensive and recent studies of such needs are at the national level. However, the findings from the studies offer insight into this population's needs in the State.

A 2001 nationwide survey of the migrant worker population by the Housing Assistance Council found that the median monthly income for migrant worker respondents was $860, and the median monthly housing cost was $345. Excluding units where no rent was charged, the median housing cost was $380. Three in five units were occupied by households with incomes at 80 percent or less of Area Median Income (AMI). Thirty-eight percent of migrant worker households surveyed had incomes of 50 percent or less of AMI, and 17 percent had incomes 30 percent or less of AMI.

The 2001 Housing Assistance Council survey indicated that 45 percent of migrant agricultural workers live in either single or multifamily housing. Employers owned 25 percent of all units, and 57 percent of employer-owned units were provided free of charge.

Serious structural problems, including sagging roofs, house frames or porches, were evident in 22 percent of the units surveyed and 15 percent had holes or large sections of shingles missing from their roofs. Foundation damage was evident in 10 percent of all units and windows with broken glass or screens were found in 36 percent of the units. Unsanitary conditions, such as rodent or insect infestation, were evident in 19 percent of the units surveyed and 9 percent had frayed wiring or other electrical problems present. More than 10 percent of units lacked a working stove, 8 percent lacked a working bath or shower and more than 9 percent lacked a working toilet.

The 2001 Housing Assistance Council survey found that crowding was extremely prevalent among migrant worker housing units. Excluding dormitories and barracks (structures designed for high occupancy), almost 52 percent of all units were crowded (defined as having a mean of more than one person per room, excluding bathrooms). Among crowded units, 74 percent had children present.

The U.S. Department of Labor's National Agricultural Workers Survey (NAWS) has been a consistent source of information on the demographics, working, and living conditions of agricultural workers in the United States. Since 1988, the NAWS has surveyed more than 25,000 workers. The most recent survey for which data are available was conducted between 1997 and 1998.

The majority of workers surveyed in 1997-1998 were paid by the hour, although this varied by type of work. About one-third of workers performing "harvest tasks" were paid piece rates (e.g., paid by amount of units harvested). The average wage earned by a worker in 1997-1998 was $5.94 per hour, and about 12 percent of all workers earned less than the minimum wage. The survey compared wages over time and found that the purchasing power of agricultural worker wages has been declining. Workers' wages have dropped (in real terms) since 1989, from $6.89 to $6.18 per hour. On an annual basis, about half of all workers surveyed reported earning less than $7,500 per year.

According to the NAWS survey, most workers did not receive benefits as part of their employment. Only 41 percent were covered by unemployment insurance and just 33 percent were covered by workers compensation insurance.

The NAWS survey included very few questions about the specific health and living conditions of agricultural workers. In the 1997-1998 survey, 2 percent of workers reported that they did not have access to drinking water at their worksite. Sixteen percent reported not having water with which to wash and 13 percent reported that toilets were not available at work.

Although most migrant workers do not have a choice about the type of housing they will have, studies have indicated that they express preferences for living in mixed or homogeneous housing. Many unaccompanied men prefer living in mixed housing because it fosters a sense of community. Families, however, prefer to be in family-only facilities. A recent survey found that most housing managers and crew leaders are wary of placing families and unaccompanied men in the same facility.

Resources. Historically, growers have provided housing for migrant workers in Indiana. These housing facilities are licensed by the Indiana State Department of Health and are held to minimum standards, including windows and a source of heat. Indoor faucets or plumbing are not required under the standards, and most camps have common showers, restrooms and facilities for washing clothes. It should be noted that structures built before the adoption of these standards are acceptable under a grandfather clause, meaning that some families live in cabins as small as 10 by 12 feet in dimension. According to service providers, grower provided housing is more common in central and northern Indiana, while workers in the southern part of the State typically find housing independently.

As of September 2003 there were 52 state-licensed migrant labor camps in Indiana. The camps provided by the growers of the agriculture produce, and the migrant workers pay rent. Anywhere from 50 to 350 live in grower-provided camps. These camps are inspected at least once a month during the growing season by the Department of Health.[9]

Aside from grower provided housing, migrant workers are left to find housing for themselves in surrounding areas. The funding sources available for the development of migrant worker housing are those used by all developers of affordable housing seeking subsidies and can be very competitive.

Several migrant farm worker housing developments have been built recently, using CDBG funding. The following exhibit shows the migrant farmworker housing projects from 1998 to the present.

Exhibit V-22.
Migrant Farmworker Housing Projects, Indiana

Grantee	Current Award	Date Board Awarded	Status
Town of Orestes	$388,900	January 2003	Open
City of Elwood	$499,000	January 2003	Open
The Board of Commissioners of the County of Knox	$400,000	September 2002	Open
The Board of Commissioners of the County of Fountain	$427,600	August 2001	Closed
Knox County	$444,500	July 1999	Closed
Elkhart County Government	$299,998	November 1998	Closed

Source: Indiana Housing Finance Agency.

[9] *Indiana Health Centers Serves Migrant Workers,* Indiana State Department of Health – Express, September 24, 2003.

In December 2003 USDA Rural Development announced a $250,000 low interest Farm Labor Housing Loan to a farm corporation to build housing in Pulaski County. This is the first time that funding for farm labor housing has been made available by USDA Rural Development in Indiana. The farm labor housing, known as Gollier City Migrant Housing Facility, consists of eight units providing housing for 48 workers. The Farm Labor Housing Loan and Grant program provides financing for the development of housing for farm laborers. Funds can be used to purchase a site or a leasehold interest in a site; to construct housing, day care facilities, or community rooms; to pay fees to purchase durable household furnishings; and to pay construction loan interest.[10]

In addition, special outreach services are provided to reach migrant worker populations through the Comprando Casa program, a homeownership education program run by Rural Opportunities, Inc. (ROI), designed specifically for the Hispanic/Latino population. In 2002, ROI received an American Express Foundation grant for *Hablemos de Dinero*, a Spanish language based financial literacy program for migrant workers throughout the State. The program also focuses on building basic money management skills. This ROI initiative is designed to help the Hispanic/Latino migrant worker population become familiar with the American banking system, decrease predatory lending, address credit issues and create a stepping stone to homeownership training. While the program provides aid to all migrant/seasonal farm workers, it specifically targets farm workers who are settling in Indiana for their homeownership training program. Additionally, ROI offers technical assistance, i.e. information and referral services to promote improvement of farm worker housing, to growers.

A Migrant Task Force has also been formed to provide information sharing and coordination of migrant worker services throughout Indiana. The task force meets monthly and includes the following members:

- Consolidated Outreach Project (provides migrant health services, referrals and follow up for other needs);
- Transition Resources (migrant employment and training services);
- Indiana Department of Education;
- Texas Migrant Council;
- Indiana Department of Labor;
- Indiana Legal Services; and
- Indiana Department of Workforce Development.

The Task Force has begun meeting and is discussing the following:

- A description of the role of the committee;
- How often the committee will meet;
- Specific targeted goals;
- Measurable outcomes; and
- Goals the committee plans to achieve.

[10] *USDA Awards Funding for Farm Labor Housing in Pulaski County,* USDA Rural Development, December 15, 2003.

Implications

The many needs of the populations discussed above, combined with the difficulties in estimating the extent of such needs, can be overwhelming. Furthermore, the dollars available to serve special needs populations are limited, and these groups often require multiple services. Exhibit V-23 on the following page attempts to identify the greatest needs of each special needs populations and shows the primary resources available to meet these needs. As discussed in the text, these needs are often more pronounced in rural areas due to lack of services.

Exhibit V-23.
Summary of Special Needs and Available Resources

Population	Housing Need	Community Need	Primary Resource Available
Youth	Affordable housing Transitional housing with supportive services Rental vouchers with supportive services	Job training Transitional living programs Budgeting	HUD's FUP Medicaid Transitional Living Program Chafee Foster Care Independence Program IHFA Education and Training Voucher Program
Elderly	Rehabilitation/repair assistance Modifications for physically disabled Affordable housing (that provides some level of care)	Public transportation Senior centers Improvements to infrastructure	CDBG CHOICE HOME/IHFA Home Equity Conversion Mortgage Program Medicaid Public Housing Section 202 Section 8 USDA Rural Housing Services
Homeless	Beds at shelters for individuals Transitional housing/beds for homeless families with children Affordable housing for those at risk of homelessness	Programs for HIV positive homeless Programs for homeless with substance abuse problems Programs for homeless who are mentally ill	ESG CDBG HOME/IHFA HOPWA IDOC ISDH County Step Ahead Councils County Welfare Planning Councils Local Continuum of Care Task Forces Municipal governments Regional Planning Commissions State Continuum of Care Subcommittee

Source: BBC Research & Consulting, 2004.

Exhibit V-23. (continued)
Summary of Special Needs and Available Resources

Population	Housing Need	Community Need	Primary Resource Available
Developmentally Disabled	Semi-independent living programs Group homes	Smaller, flexible service provision Community settings for developmentally disabled Service providers for semi-independent Integrated employment programs	CDBG CHOICE HCBS HOME/IHFA SSI Medicaid Section 811 Olmstead Initiative Grant DDARS BDDS Supported Living Supported Group Living
HIV/AIDS	Affordable housing for homeless people with HIV/AIDS Housing units with medical support services Smaller apartment complexes Housing for HIV positive people in rural areas Rental Assistance for people with HIV/AIDS Short term rental assistance for people with HIV/AIDS	Support services for AIDS patients with mental illness or substance abuse problems Medical service providers Public transportation	HOME/IHFA HOPWA Section 8 ISDH
Physically Disabled	Housing for physically disabled in rural areas Apartment complexes with accessible units Affordable housing for homeless physically disabled	Public transportation Medical service providers Integrated employment programs Home and community-based services	CDBG CHOICE HOME/IHFA SSI Medicaid Section 811

Source: BBC Research & Consulting, 2004.

Exhibit V-23. (continued)
Summary of Special Needs and Available Resources

Population	Housing Need	Community Need	Primary Resource Available
Mental Illness and Substance Abuse	Community mental health centers Beds for substance abuse treatment Supportive services slots Housing for mentally ill in rural areas	Substance abuse treatment Education Psychosocial rehabilitation services Job training Medical service providers	CDBG HOME CHIP Division of Mental Health Section 811 Hoosier Assurance Plan Olmstead Initiative Grant
Migrant Agricultural Workers	Grower-provided housing improvements Affordable housing	Family programs Public transportation Homeownership education	CDBG Rural Opportunities, Inc. Comprando Casa Program USDA Rural Development 514 & 516 Programs

Source: BBC Research & Consulting, 2004.

Data Sources

A number of data sources were relied upon in the preparation of this section, including key person interviews with government and non-profit service providers and advocates, and multiple primary and secondary documents. The following documents were used in the preparation of this section:

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Persons Contacted

In addition to the aforementioned data sources, a number of people with specific knowledge of various special needs populations furnished information either electronically or by telephone that were used in preparation of this section. We thank these individuals for their very helpful assistance.

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- Dr. Patricia Rogan, Indiana University, Bloomington, IN, Institute for the Study of Developmental Disabilities;
- Marge Slauter, Family and Social Services Administration;
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- Patrick Taylor, Indiana Coalition on Housing and Homelessness Issues; and
- Mary Lou Terrell, Knox County Housing Authority.